Testimony
of
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Interim Health Commissioner
New York City Department of Health and Mental Hygiene
before the
New York City Council Committee on Health
on
Examining the Effects of Hospital Closures on Community Needs

October 29, 2024
City Hall
New York, NY

Good morning, Chair Schulman, Chair Narcisse, and members of the Committee on Hospitals and the Committee on Health. I am Dr. Michelle Morse, Interim Health Commissioner at the New York City Department of Health and Mental Hygiene. I am joined here today by my colleague Dr. Laura Iavicoli, Chief Medical Officer from New York City Health + Hospitals Elmhurst. Thank you all for the opportunity to testify today on the Effects of Hospital Closures on Community Needs in New York City. The mission of the New York City Health Department is to improve and protect the health of all New Yorkers and to promote health equity. As you are well aware, hospitals are an essential infrastructure and vital partners to the New York City Health Department. I have witnessed the impacts of hospital closures firsthand as a medical doctor. These closures pose significant risks and wide-ranging impacts on communities, patients, health care workers, public health, socio-economic stability and the overall health care system, especially hospitals located in marginalized communities. But before we address solutions, we must identify the problems.

Today I will outline the business of health care in the context of structural racism as a root cause of hospital closures, and the critical role of safety net hospitals for health equity for our city.

The New York City Health Department does not regulate health care, including hospitals. Under New York State law, that authority lies with the New York *State* Health Department. However, we do have a critical role in using data, narrative-change, community engagement, and technical assistance to ensure a more accountable and equitable health care system. As a public health agency, we analyze and describe root causes of inequitable health outcomes. I have previously addressed the impact of structural racism and economic inequity on our health care system during last year's hearing on health care accountability. For example, structural racism and health care business practices – such as decisions about what insurance plans to accept, what prices to charge, where to build facilities, and how to distribute resources and services between facilities – are clear and entrenched causes of hospital closures and health inequities in New York City.

Hospital closures are not an unfortunate side effect in our health care system; rather, such closures are a central feature of a highly inequitable system and related payment and policy choices. As I testified last year, New York City is one of the most racially segregated health care markets in the United States. Many New Yorkers know this from experience.

Our public and private safety-net hospitals and facilities care for more of the city's low-wealth and Black, Indigenous, and people of color populations. Racial segregation in health care is in part maintained by reimbursement systems that directly incentivize health care providers to deliver care to those who can pay more. Our health care system routinely prioritizes those who can pay more and those who are commercially insured, at the direct expense of those who pay less – such as those who do not have insurance.

The power inequities that result means that it is often easier to close a hospital if the people who use that hospital are not considered important. Their voices are more likely to be ignored, and their health care needs are more likely to be sidelined. Teams at the New York City Health Department are implementing City Council's recent health care accountability mandate, through the passage the Health Care Accountability and Consumer Protection Act – or Local Law 78 of 2023, and

using an approach that combines data, direct engagement with New Yorkers, and policy development to address the root causes of health care segregation in New York City.

Institutional accountability has been a strategic focus during my tenure as the New York City Health Department's Chief Medical Officer and will continue to be a strategic focus in my new role as Interim Commissioner. We are committed to working with all nonprofit hospitals in New York City to ensure they provide high-quality care for all, regardless of immigration status, race, ethnicity, ability to pay, or other social factors. Furthermore, our aim is to work alongside hospitals and health care systems to identify business practices and behaviors that have led to systemic inequities, including segregated care, and address harms.

More can be done to equip hospitals and health care systems with the tools they need to hold themselves accountable by taking measurable, verifiable steps to combat structural racism and promote health equity. One useful example: in Illinois, health care leaders have created a statewide Racial Health Equity Progress Report Action Tool which is a self-assessment questionnaire that hospitals and health systems can use to measure their performance addressing racial health and other health inequities. This is a valuable tool that highlights the importance of examining all aspects of an organization — not patient care alone — to successfully eliminate health inequities. Actionable tools like this can help organizations measure their progress over time, support greater transparency around their actions and decisions, and promote accountability.

Nonprofit hospitals receive substantial public subsidies in the form of tax exemptions. According to a 2022 report by the Lown Institute, 21 New York City hospitals received over, an estimated, $1.5 billion in federal, state, and local tax exemptions.[1] To earn these tax benefits, hospitals must legally provide a community benefit. Several major New York City private hospitals have what Lown identifies as a "Fair Share" deficit — spending less on *"meaningful"* community health initiatives than the value of the tax exemptions they receive. This spending data reveals that some New York City hospitals have a deficit of hundreds of millions of dollars. When not all institutions do their part to care for uninsured and publicly insured patients the inequities that are created are compounded when unfairly overburdened safety-net hospitals are left to face increased demand.

In addition to my role as Interim Health Commissioner, I am a practicing physician at New York City Health + Hospitals/Kings County, a public institution that is located in a community that has inequitable health outcomes and would be deeply impacted by hospital closures. Supporting safety net hospitals has also been a focus of mine throughout my tenure at the New York City Health Department. The impacts of hospital closures are unfairly felt by communities that have faced decades of disinvestment. During the proposed closure of SUNY Downstate, the New York City Health Department shared concerns regarding this closure and advocated to the New York State Department of Health for key steps to limit harm to the local community and to advance health equity in Brooklyn. A key recommendation included in the New York City Health Department's letter to the State was the development of an advisory board which is currently being created and will be led by the New York State Health Commissioner, Dr. Jim MacDonald.

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[1] Lown Institute, Are New York City Hospitals Earning Their Tax Breaks? A Fair Share Spending Analysis (2022), lown-fair-share-nyc-20221118.pdf (lowninstitute.org).

I will now provide an overview of our sentiments: Firstly, the importance of safety net hospitals cannot be overstated. They provide indispensable services that ensure access to health care for all individuals, contribute to public health, support the economy, and help build a more equitable health care system. Their role is fundamental in promoting the health and well-being of communities, particularly those that are most in need. Secondly, safety net hospitals are under-resourced at baseline because of how the health care payment system is built. Most notably, some services, such as specialty care are reimbursed at higher rates than other services, and commercial, private insurance also reimburses at higher rates than public insurance programs, such as Medicaid and Medicare. In addition, essential services such as maternal and neonatal, mental health, and injury services are disproportionately provided by safety-net hospitals.[2] However, these essential services are less profitable, placing financial strain on safety-net hospitals. People in communities with unfair health outcomes are more likely to be hospitalized and, are more likely to seek care at safety net hospitals, straining safety-net hospital capacity. Despite these headwinds. safety net hospitals continue to provide high-quality care. I serve alongside committed providers when I work at H+H/Kings County.

In addition to providing high-levels of uncompensated care, many safety net institutions also provide services to address social needs such as food and housing assistance that shape health.

The New York City Health Department supports state-level proposals that aim to address persistent funding gaps for safety-net hospitals. These include expanded Medicaid access to historically excluded populations, use of the state's 1115 Medicaid waiver, exploration of all-payer rates and other forms of Medicaid payment parity, and adequate funding and equitable distribution of Indigent Care Pool and similar funds. The New York State Department of Health's Study of Health Care System Inequities and Perinatal Access in Brooklyn serves a recent example of using some of these state levers to support safety net institutions and address inequitable access to care. The Study highlights New York State actions such as the launch of the Safety Net Transformation Program, increased Medicaid primary care rates, and expanded access to Medicaid and Child Health Plus through an 1115 waiver amendment.

Some safety net hospitals have experienced increased overcrowding and wait times in their emergency departments, which can be dangerous and lead to increased mortality risk. As we have documented in our research on COVID-19 hospitalizations and inequities, these closures contributed to a surge in patient load during the first wave of the COVID-19 pandemic that was not adequately spread across safety net and non-safety net hospitals and led to preventable deaths across the city. Emergency department overcrowding may be made worse with the closure of a nearby hospital.

Safety-net hospital closures are part of a vicious cycle. Demand by the health care industry for maximum profits in all areas of health care and a lack of accountability when large public subsidies are given in the form of tax exemptions to nonprofit hospitals pose threats to safety-net hospital

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[2] Sutton JP (Social and Scientific Systems), Washington RE (Council for Affordable Quality Healthcare), Fingar KR (Truven Health Analytics), Elixhauser A (AHRQ). Characteristics of Safety-Net Hospitals, 2014. HCUP Statistical Brief #213. October 2016. Agency for Healthcare Research and Quality, Rockville, MD. http://www.hcup-us.ahrq.gov/reports/statbriefs/sb213-Safety-Net-Hospitals-2014.pdf.

viability and the patients and families they serve. Addressing these dynamics requires proactive work on the part of state and local health departments.

Thank you for holding this hearing today. Hospital closures are a direct consequence of structural racism. Closures represent a failure of health policy and medical institutions to meet their responsibility, and of government to set the proper incentives for institutions to do better. We look forward to working with the Council to further our commitment to health care transparency, accountability, and equity. Thank you for the opportunity to testify and I am happy to answer any questions.

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Testimony for NYC Council Oversight Hearing: Examining the Effects of Hospital Closures on Community Needs
October 29, 2024
NYS Senator Gustavo Rivera

I would like to thank my colleagues in the New York City Council, including Health Chair Lynn Schulman, Hospitals Chair Mercedes Narcisse and the members of New York City Council Committees on Health and Hospitals, for taking the time to focus on a very important issue. Hospital closures have a profound impact on the communities they serve. Current state law does not go far enough to regulate this process and account for the community impacts that a closure has. Just this year, we have seen the anxiety and fear a closure announcement causes in Manhattan and Brooklyn. I'd like to outline the failures I have seen in our current system, solutions to address those failings, including my bill with Assembly Member Jo Ann Simon that is awaiting the Governor's signature, and actions I have taken in my role as Chair of the New York State Senate Committee on Health to enact those solutions.

Currently in New York State, the only statutory requirement relating to community input on the closure of a general hospital is the requirement for a community forum that does not legally need to take place until 30 days after a facility has closed. The stated purpose of this community forum is to obtain public input concerning the anticipated impact that the closure will have on access to health care services. The current law also has a stated goal of mitigating the effects that a closure may have on the community it's serving or putting in place contingency plans. By structuring the closure process in a way that only allows for input from community stakeholders after a closure has happened, we have set ourselves up for failure. Members of our community rely on these services on a daily basis, and without a viable alternative, many find their ability to access critical health services significantly reduced or eliminated. The state should not wait until after a closure has already happened to take action to either mitigate issues caused by a closure or respond to concerns from the community.

To address this, I worked with Senator Kavanagh and Assembly Member Simon, my other Senate and Assembly colleagues, advocates, as well as representatives of general hospitals to introduce a new bill this year, S8843A. This bill replaced S2085, which was mentioned in the New York City Council's Resolution 339. Together with Assembly Member Simon, we passed this bill in both houses of the Legislature and await a decision by Governor Hochul. I hope that the NYC Council and New Yorkers impacted by hospital closures will join me in advocating for her to sign this important bill. In full disclosure, many hospitals remain displeased about aspects

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of the legislation, but we did our best to accommodate the concerns that all stakeholders raised while advancing a bill that would have a significant and meaningful impact on the process.

The bill makes a number of changes to the state's review process. To highlight a few, the bill significantly moves up the timeframes connected to a closure to provide the public and health officials adequate time to weigh in on the proposed closure prior to its approval and to take action to ensure that those that rely on the hospital can continue to access the services they need. Additionally, we have added unit closures into this process with a separate timeline.This includes the expansion of public notification and increased opportunities for individuals to submit comments on a proposed closure. The bill would also require a health equity impact assessment (HEIA) to be performed for any proposed closure. The HEIA statute, which I proudly passed in 2022, requires an independent entity to perform an analysis on key metrics that may impact access to care in the surrounding community. Additionally, the bill would require any closure plan to be updated to reflect community stakeholder feedback. All of these changes and others in the bill are aimed at minimizing the disruptions that occur should a closure take place and give the Department of Health adequate information from the hospital and the community as they decide whether or not to approve it at all.

Hospital and unit closures happen for a variety of reasons and some closures may be outside of our ability to control, or may make sense when combined with a sensible transition plan for impacted communities. Typically, we see hospital or unit closures resulting from a financial decision made by the hospital's operators. This may be because the hospital's capital expenses for operating the facility are exceeding the incoming revenues. In other instances there may be an oversaturation of services in a given area. I would also point out that hospitals are not the most efficient means of delivering certain types of care. We must look at the underlying incentives that drive our healthcare delivery system. Under our current structure we have seen a recent proliferation of hospitals on the Upper East Side. Meanwhile residents in other areas, including my home borough of the Bronx, are struggling to access care. I believe this is a failure of the state and the inadequate investment into Medicaid rates which does not cover the cost of care for safety net hospitals, which are more vulnerable to closure. If profitability remains the primary motivator for these decisions, we should brace ourselves for more closures that will have irreparable impacts on the communities that are deprived of hospital services.

One of the things that can relieve the strain on hospitals, and patients who depend on them for care is investments in community-based providers and primary care services. These providers and services should serve as the front lines of health care delivery for the majority of New Yorkers instead of emergency rooms. This would allow the hospitals to scale themselves more appropriately and focus their resources on the core services that they excel at. A hospital closure or downsizing becomes much less concerning when there is a robust network of community-based providers that can absorb patients that may be in search of a new provider. To this end, I have legislation (S1197B/A8592) that would require insurance plans, including Medicaid, to gradually increase their spending on primary care services until total spending reaches 12.5%. When we look to other countries with better health outcomes, one of the consistent metrics is a greater investment in primary and preventive care. I carry a number of

other pieces of legislation aimed at strengthening community-based providers including federally qualified health centers (FQHCs). Additionally, I am pushing for a portion of any funding received through the recently enacted Managed Care Organization (MCO) tax to be invested in primary care and FQHCs.

Another way we can address this issue is through Medicaid reimbursement rates. Hospitals that have a large patient population of Medicaid recipients are often struggling to keep the lights on and make payroll. Inadequate Medicaid rates are one of the primary reasons many hospitals lose money. Typically, facilities rely on other payor types such as private insurance to offset these losses. This creates an inherent incentive for hospitals to leave areas with higher numbers of New Yorkers on Medicaid or without insurance and to instead serve areas with higher rates of private insurance. I have been pushing for years to make meaningful investments in Medicaid rates to combat this root cause of our state's health disparities. While we have been able to achieve some small investments in this space, more significant ones are still needed. Please join me next year in defending this crucial program from cuts in the State budget when it desperately needs sustained investment.

Along similar lines, hospitals lose money treating individuals who are completely without insurance coverage. Hospitals receive payments for uncompensated care primarily through Emergency Medicaid. The immigrant community typically does not have access to the other publicly subsidized health programs or the resources to directly purchase private insurance. In New York State, we spend over $1.1 billion dollars a year on Emergency Medicaid, and New York City accounts for just over $870 million of that spending. My bill, which I sponsor along with Assembly Member Gonzalez-Rojas, is known as Coverage For All (S2237B/A3020B). This bill allows surplus federal funding to be used to provide coverage under the 1332 waiver program, which is sometimes referred to as the Essential Plan or the Basic Health Plan. This would expand coverage and help the state save hundreds of millions of dollars by avoiding unnecessary and costly emergency visits and creating a more stable funding source for the hospitals when they are providing care.

When examining the impact of closures, it's important to look at the whole picture, which includes where new hospitals are being opened. The State's Public Health and Health Planning Council (PHHPC) is tasked with reviewing the need for the construction of a new hospital, sometimes referred to as the certificate of need (CON) process. Even if every new hospital is appropriately located at the time of its establishment, it may not be meeting the needs of New Yorkers down the road. However, I believe that new facilities are not appropriately located to address the needs of New Yorkers. PHHPC's membership is primarily composed of individuals representing health systems and hospitals. In 2019, I worked with Senator Hoylman and former Assembly Member Gottfried to advance legislation (S870/A4071 of 2019) to expand PHHPC to include additional representatives like advocates for consumers with a focus on moderate- and low-income households, as well as those representing organized labor and workers. The bill would have also included representatives appointed by the Legislature. While the bill passed both houses, it was vetoed by former Governor Andrew Cuomo. In his veto decision, he stated that he would appoint an additional representative of consumer interests for a grand total of two

representatives. Two representatives out of a total 24 members does not represent a meaningful voting bloc that can adequately represent the interests of your average New Yorker. In the veto message, the former governor also said that “PHHPC exercises powers that are beyond mere recommendations.” PHHPC does exercise significant control over the healthcare services delivered to millions of New Yorkers and the people making those decisions should not have a vested financial interest in the outcomes. We must continue to advocate for meaningful reforms so this body’s power serves the interests of patients.

There are a number of different ways to address the issue of hospital closures. The most direct and immediate are the oversight expansions for the Department of Health and community stakeholders for closures included in my bill, the Local Input in Community Healthcare Act. Sustained and adequate investments across our healthcare delivery system that allow hospitals to be appropriately sized and to focus on the core services they need to provide would create more durability in our system. A robust network of community-based providers allows for a community to more effectively absorb the ripple effects that a closure may have. Stronger patient and planning-focused oversight means that hospitals are less likely to compete if there is a more even geographic distribution of their services to improve access.

There isn’t a silver bullet to fix the issues connected to the disruptive trend of hospital closures in New York State, but with smart and forward thinking policy in place, New Yorkers would enjoy a more dependable healthcare system that diversifies and strengthens their healthcare options. Thank you again for your time and I’m happy to answer any questions you may have.

THE ASSEMBLY

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HARVEY EPSTEIN
Assemblymember 74th
District

My name is Harvey Epstein, and I am the Assemblymember representing New York's 74th Assembly District, which includes the neighborhoods of the Lower East Side, East Village, Stuyvesant Town/Peter Cooper Village, Murray Hill, Tudor City, and the United Nations. Thank you for the opportunity to testify regarding the impact of hospital closures on communities. I would like to speak regarding my experience with the closure of Mount Sinai Beth Israel in my district.

I strongly oppose Mount Sinai Beth Israel's approved plan for closure, as it will disproportionately affect low-income patients from medically underserved communities, strain other hospitals, and limit access to essential medical services. **Therefore, I call on the City Council to pass Reso. Res 0022-2024 and put pressure on the Governor's office to reverse their decision on the closure.**

Threaten access to crucial medical services

The closure of Mount Sinai Beth Israel poses a significant threat to the healthcare access of the diverse Lower East Side community. With the closure of two downtown hospitals in the last two decades, the reliance on Beth Israel for medical care has become crucial. Longer travel times for emergency care could mean life or death for patients experiencing time-sensitive emergencies such as strokes and heart attacks.

Additionally, the closure will lead to increased demand for services at other hospitals, putting a strain on healthcare resources. Lower Manhattan seriously lacks hospital capacity, with only 0.81 hospital beds per 1,000 residents below 14th Street, less than half the statewide rate of 2.4 beds per 1,000. NYU Langone has seen a 32 percent increase in emergency room visits from patients in Beth Israel's coverage area, according to the New York Times. Additionally, Bellevue Hospital will absorb much of the emergency care but the necessary expansion will take several years to accomplish, leaving our neighbors in a precarious situation in the meantime.

Impact on vulnerable populations

This planned closure will particularly impact vulnerable populations, including low-income individuals, the uninsured, the disabled, and those with critical medical conditions. Many of the hospital's patients fall into these categories, and the closure will only exacerbate existing

healthcare inequalities, making it even more challenging for these individuals to access the care they need. According to a community-led health equities impact assessment, the top two zip codes from which Beth Israel patients originate (10002 and 10009) have some of the city's poorest residents and high percentages of people of color. In zip code 10002, the median household income is only $46,000, and a quarter of the residents live in poverty. Access to equitable healthcare is paramount for the community.

Importance of community engagement

Mount Sinai Beth Israel's lack of community engagement around its closure undermined the community's ability to adapt to the loss of services, left critical health and social concerns unaddressed, and damaged the relationship between the healthcare system and the people it serves. When a hospital closes, it is essential for robust community engagement to occur so that the population it serves is informed on what is happening and their needs are taken into account.

I call on the City Council to pass Reso. Res 0022-2024 and put pressure on the Governor's office to reverse their decision on the closure of Mount Sinai Beth Israel.

Thank you again for the opportunity to offer testimony.

JUMAANE D. WILLIAMS

TESTIMONY OF PUBLIC ADVOCATE JUMAANE D. WILLIAMS TO THE NEW YORK CITY COUNCIL COMMITTEES ON HEALTH AND HOSPITALS
OCTOBER 29, 2024

Good morning,

My name is Jumaane D. Williams, and I am the Public Advocate for the City of New York. I thank Chairs Schulman and Narcisse and the members of the Committees on Health and Hospitals for holding this hearing today.

Four years ago, the COVID-19 pandemic changed the world as we knew it. In New York City, which quickly became the epicenter of the virus in the US, we saw our hospitals on the verge of collapse, our medical staff overworked and overwhelmed, constantly at risk as PPE resources stretched thin. Today, we stand on the other side of that pandemic with COVID-19 a part of our new normal and our healthcare system remains in crisis with understaffed and under resourced hospitals and clinics and even more closures on the horizon.

Over the past 25 years, we've had a total of 20 hospital closures. These closures have disproportionately impacted communities of color who often bear the burden of adverse health effects. We stand to lose an additional two hospitals in the coming years: Mount Sinai Beth Israel on 16th Street and First Avenue in Manhattan and SUNY Downstate Medical Center in Brooklyn. In losing these hospitals, we are losing access to beds and precious resources. We cannot afford to go further back.

Recently, doctors at Health + Hospitals (H+H) were instructed to cut patient visits from 40 minutes to 20 minutes — a measure meant to allow more patients to be seen as demand for care grows. Since 2021, H+H systems have added roughly 50,000 unique patients to their care leading to longer wait times for an appointment but limiting the time per patient visit runs the risk of diminishing quality of patient care and further contributing to burnout amongst physicians.[1] When it comes to migrant populations, it is important to remember that many patients would require translation services lengthening the duration of visits. Given the difficult journey here as well as circumstances in their home countries, these patients may require more treatment and attention for underlying health concerns. Furthermore, the lasting impacts of long-COVID still affect many New Yorkers today and we have put no long term resources into

[1] gothamist.com/news/nyc-public-hospital-doctors-ordered-to-shorten-appointments-to-see-more-patients

addressing that reality.

Not only was this a decision made without the consultation of doctors and their representation at Doctors Council SEIU, but this decision further fails to address the lack of retention and recruitment contributing to burnout and high rates of turnover.[2] After a year of contract negotiations with Health and Hospitals' affiliates – Physician Affiliate Group of NY (PAGNY), Mt. Sinai, and NYU Langone – the Doctors Council is no closer to a contract that addresses the concerns of its members. As a city, we simply cannot allow our public health system to collapse– and right now our system is stressed.

In the case of SUNY Downstate, many inpatient services would move to Health and Hospital's Kings County hospital, which is already stretched thin. According to Redetha Abrahams-Nichols, president of the Downstate chapter of United University Professionals (UUP), this spring saw the emergency room at Kings County packed with 80 patients sitting "without beds on the floor" with wait times "over 12 hours."[3] Similarly, in the case of Beth Israel, the hospitals closest by (NYU Langone Health and the city-run Bellevue) would be impacted. This follows the closure of two large nearby hospitals in the past 20 years: Cabrini in Gramercy Park and St. Vincent's in Greenwich Village.[4]

City and state elected officials must come together to address these issues and ensure that our public health system is fully staffed and fully funded with dignity and care ensured for patients and healthcare workers alike. Thank you.

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[2] Ibid.

[3] https://indypendent.org/2024/03/death-by-a-thousand-cuts-community-leaders-unite-to-save-stronghold-of-brooklyn-healthcare/

[4] https://www.nytimes.com/2024/07/26/nyregion/mount-sinai-beth-israel-hospital-closure.html

Oversight - Examining the Effects of Hospital Closures on Community Needs

New York City Council Joint Hearing of the Committee on Health and Committee on Hospitals

Chatodd Floyd, Senior Vice President of Legislative Affairs

GREATER NEW YORK HOSPITAL ASSOCIATION

Committee Chairs Schulman and Narcisse and members of the Health and Hospitals Committees, thank you for the opportunity to testify today. I am Chatodd Floyd, Senior Vice President of Legislative Affairs for the Greater New York Hospital Association (GNYHA) and I am joined by my colleague, Andrew Title, Vice President of Government Affairs. GNYHA proudly represents not-for-profit and public hospitals, health systems, and continuing care providers around the tri-state region, including 170 hospitals and health systems and 54 continuing care facilities in New York State.

GNYHA is committed to ensuring that no hospital has to close its doors. However, after years of struggling against insurmountable challenges, some hospitals have no choice. They have been suffering from chronic Medicaid underpayments, rising operational costs (including large increases in pharmaceutical expenses), and abusive tactics by health insurance companies to delay and deny care.

We are fighting for Medicaid Equity in Albany alongside our partners, 1199SEIU United Healthcare Workers East, so hospitals can keep their doors open and provide quality jobs, and New Yorkers can access equitable, high-quality health care. We are grateful for the Council's past support and urge you to continue standing with us to support Medicaid reimbursement rates that cover the cost of delivering care.

While we have seen prominent hospitals announce closures over the last year, this situation is not new. It is a byproduct of decades of Medicaid underfunding and the long-term, cumulative effect of Medicare cuts under the Affordable Care Act. Today, I want to discuss why some hospitals are being forced to close.

Hospitals Under Fire

Hospitals do not close because they want to; they close because they are no longer financially viable. Some hospitals simply cannot continue to operate in the red year after year without external help. These institutions are under fire, and when help doesn't arrive, they are left with no choice but to shut down or cut back on services.

As New York Governor Kathy Hochul noted in her State of the State address in January, "hospitals in New York are struggling financially more than in the rest of the U.S—42% of hospital facilities in New York had an operating deficit in 2021." The Governor did not mention that the figure rose to 63% in 2022, in a year in which New York hospitals experienced a median operating margin of -2.8% and three out of for New York hospitals experienced an "unsustainable" margin.[1] Experts, including the Medicare Payment Advisory Commission (MedPAC), an independent committee that advises Congress on Medicare payment issues, have determined that hospitals require an operating margin of at least 3% to be sustainable. Without such a margin, they cannot reinvest in patient care services and hospital infrastructure such as capital improvements and information technology.[2]

A fundamental issue contributing to unsustainable hospital margins is that New York's Medicaid program reimburses hospitals 30% less than the actual cost of delivering care—a direct result of years of disinvestment in a program that covers almost 40% of New

[1] GNYHA analysis of 2022 NYS Institutional Cost Reports.
[2] The Medicare Payment Advisory Commission (MedPAC) has determined that hospitals require an operating margin of 3% to be sustainable and support reinvestment in patient care services and hospital infrastructure such as capital improvements and information technology.

Yorkers. Medicaid reimbursement rates remained essentially flat for 15 years (2008-2022) while general inflation, as measured by the Consumer Price Index, rose 35% and medical inflation rose 50% over that same period. While the State budget has included modest Medicaid rate increases the past two years, our hospitals still lose money on every Medicaid patient they treat.

Our safety net hospitals, which primarily serve Medicaid and Medicare patients and the uninsured, are the most at-risk. Our collective failure to invest in hospitals and properly address various other social determinants of health, has disproportionately impacted communities of color. The grave consequences of inaction include further deterioration of health outcomes in Black and Brown communities, declining access to care, reduced services, and inevitable hospital closures—very possibly in your neighborhood.

GNYHA and 1199SEIU are fighting for Medicaid equity in Albany so hospitals can be there for New Yorkers. The GNYHA/1199SEIU Healthcare Education Project (HEP) has entered Year 2 of a comprehensive campaign to 1) persuade Albany to increase New York's Medicaid reimbursement rate for hospitals to 100% of the cost of care and 2) strive for health care justice for all New Yorkers by reducing health care disparities and improving health outcomes for low-income, predominantly Black and Brown communities.

We have a moral imperative to ensure access to quality health care. Medicaid rates have fallen short of that imperative, threatening the viability of New York's hospital infrastructure. This year, we were incredibly appreciative of Chairwoman Narcisse for her resolution supporting Medicaid Equity and organizing a rally to amplify our efforts to protect hospitals, which resulted in a 4% Medicaid rate increase for hospitals. We also

thank all the Councilmembers who were able to attend and stand alongside Chairwoman Narcisse and HEP. As we gear up for the legislative session in Albany, we urge the City Council to continue to help amplify the need for Medicaid investments to prevent future closures.

The Community Impact of Hospital Closures

Our member hospitals recognize their vital role as caregivers, and employers. Their mission is to take care of the patients and communities they serve. We recognize how daunting a hospital closure is for the affected neighborhoods.

Running a hospital is a privilege, a responsibility, and an immensely challenging task. Hospital administration and governing bodies consider all options, often for years, before considering closure. But we recognize that historically this process occurred mainly behind closed doors. Until relatively recently, community engagement has not been required until *after* closure. Under an August 2023 New York State Department of Health directive, hospitals are now required to provide 90 days' notice of any closure or cessation or pause of a service, including mandatory community input via a Health Equity Impact Assessment.

GNYHA supports this strengthened community engagement for hospital closures. We must ensure public confidence and sufficient community input into plans for mitigating the impacts of such closures. However, legislation recently passed in Albany (but not yet signed into law), the "Local Input in Community Hospitals Act (LICH)," goes too far. This well-intentioned but misguided bill not only reforms the hospital closure process, but also

addresses closures of hospital units and other service changes. It outlines specific timeframes, deliverables, and enhanced State oversight, including Health Equity Impact Assessments and Public Health and Health Planning Council review and recommendation.

While this may sound reasonable, this bill would impede health care innovation and care delivery transformation, which is ultimately to the detriment of the patients and communities we serve. The LICH Act's extensive process for evaluating unit closures and service reductions, coupled with multiple layers of assessment, risks creating a bureaucratic bottleneck that could paralyze necessary health care transformation efforts.

While there has rightly been attention on closures, the far more common motivation behind changes within a hospital reflects positive developments—innovation, modernization, and responding to the community's evolving needs. As new technology, medicine, and best practices for care delivery change, our facilities need flexibility to "rightsize" their departments and service lines. The clinical and technological advances that have driven the ongoing shift from inpatient to outpatient care are only one example and reflect the future of health care.

We welcome the opportunity for more thoughtful discussion about managing hospital closures and promoting community engagement without impeding health care transformation.

Conclusion

Our goal is to serve communities effectively. As public servants, you know the immense level of responsibility that is required. In the face of enormous fiscal pressures, our member hospitals remain committed to high-quality clinical care and community services such as health screenings, counseling, workshops, and partnerships with local organizations and City programs like HealthyNYC. We ask the City Council to help us fight for more significant investments in hospitals. Thank you for the opportunity to testify. I am happy to answer any questions.

Subject: Opposition to the Closure of Mount Sinai Beth Israel Hospital

Councilmembers, staff, and members of the public,

My name is Andrea Gordillo, and I am the Chairperson of Manhattan's Community Board 3. I'm here to testify in expressing our strong opposition to the proposed closure of Mount Sinai Beth Israel Hospital on East 16th Street. This facility is a vital asset to our community, providing essential healthcare services to a diverse and vulnerable population.

As outlined in the resolution adopted by Community Board 3 last year, the closure of MSBI would have a significant negative impact on our district. The hospital serves a large portion of Manhattan Community District 3, including residents who face economic challenges and rely heavily on the services provided. The loss of MSBI would exacerbate existing healthcare disparities, leaving many vulnerable individuals without access to necessary medical care.

Together with the local coalition, we conducted a health equity impact assessment to analyze the potential consequences of the closure. Preliminary results indicate that emergency care is the most utilized service at MSBI, followed by surgery, testing, and cardiac care. The proposed closure would force patients to travel longer distances to access these services, creating barriers for those who cannot afford private transportation.

Furthermore, the closure of MSBI would have a detrimental impact on our community's ability to respond to emergencies. As we witnessed with the 9/11 attacks and the COVID-19 pandemic, having a well-equipped hospital in our district is crucial for ensuring the safety and well-being of our residents.

In conclusion, Community Board 3 urges the New York City Council to oppose the closure of Mount Sinai Beth Israel Hospital. This vital institution provides essential healthcare services to our community and plays a critical role in addressing healthcare disparities. We believe that it is essential to preserve MSBI as a cornerstone of our healthcare system.

Sincerely,

Andrea Gordillo

Manhattan Community Board 3 Chairperson

October 25, 2024

6. Vote to adjourn
   approved by committee

29 YES 0 NO 0 ABS 0 PNV MOTION PASSED

Health, Seniors, & Human Services / Youth, Education, & Human Rights Committee

1. Approval of previous month's minutes
   approved by committee
2. Manhattan Legal Services: informational presentation on free legal services for students experiencing school avoidance and chronic absenteeism
   no vote necessary
3. CB 3 position on closing of Mount Sinai Beth Israel (MSBI) 16th St campus

VOTE: TITLE: Community Board 3 Opposes the Closure of Mount Sinai Beth Israel Hospital

WHEREAS, Mount Sinai Beth Israel (MSBI) has presented plans to close the 16 Street campus citing in-hospital patients down to a capacity of 20 % and financial losses. The community in the MSBI service area is currently conducting a health equity impact assessment to analyze the concerns regarding this proposed closure of MSBI. Preliminary results of this survey show that the greatest concern is the loss of emergency room services. In 2022, MSBI emergency department received 70,252 visits[1]. It is established that Bellevue Hospital's emergency room is over extended and cannot accommodate for the needs of the district, and

WHEREAS, the service area for this facility includes all of Manhattan Community District 3 (CD 3), and is comprised of a diverse population facing economic challenges where 27% of residents live below poverty level; 23% of the residents are over 65 and 44% of the seniors are below the poverty level, and

WHEREAS, the proposed closure of Mount Sinai Beth Israel Hospital on E.16th Street would exacerbate the healthcare disparities within our district, leaving vulnerable populations without accessible medical facilities;

WHEREAS, Lower Manhattan had 4 of the top 6 zip codes with patient discharges in NYC from the Mount Sinai Beth Israel 16th Street Campus, including zip codes 10009, 10002, 10003 and 10011. CB 3 plus Stuyvesant Town has approximately 30% of the discharges from the last year. Preliminary results from the Community Health Equity Impact Assessment show that emergency care is the top reason why people use Beth Israel as well as surgery, testing, and cardiac care, and

WHEREAS, MSBI services have been and will continue to be transferred to other facilities in the MS network, but these are not accessible by public transportation to the Lower East Side community. This means lower income residents who cannot afford private transportation will not have accessible transportation to access medical services. It requires several subway transfers and is a hardship for the sick, elderly and very young, These limited transportation options in our district create an additional barrier to healthcare access for our residents, making the closure of Mt. Sinai Beth Israel Hospital even more detrimental to our community; and

WHEREAS, CB 3 believes this closure will not serve the community, especially in a community where the number of very old is increasing. The rate of fall-related hospitalizations among older adults in CD3 is higher than the Manhattan and city-wide rates. [2] There is also concern about emergencies such as natural disasters, man made disasters, epidemics, pandemics or any number of emergencies, known or yet-to-be known such as we experienced with 9/11 and COVID.

THEREFORE BE IT RESOLVED, Community Board 3 vehemently opposes the closing of Mt. Sinai Beth Israel as this would have a detrimental impact on the community.

4. CB 3 position regarding eviction of migrant families from shelters after 60 days resulting in hardship for children to remain in their schools.

VOTE: TITLE: Community Board 3 Opposes the 60-Day Limitation on Shelter Stays for Families of Public School Students

1. **WHEREAS,** on October 11, 2023, Mayor Eric Adams announced that New York City would limit shelter stays for asylum seeker families with children living in the Humanitarian Emergency

1 Mount Sinai Beth Israel Closure Plan for 16th Street Campus PFI #1439
https://www.mountsinai.org/files/MSHealth/Assets/MSBI/MSBI-Closure-Plan-PFI1439-with-Cover-Letter.pdf
2 New York City Department of Health Community Health Profiles. https://a816-health.nyc.gov/hdi/profiles/

THE CITY OF NEW YORK
MANHATTAN COMMUNITY BOARD SIX
211 EAST 43RD STREET, SUITE 1404
NEW YORK, NY 10017

Testimony to the New York City Council Committee on Hospitals and Committee on Health at their Oversight Hearing Examining the Effects of Hospital Closures on Community Needs

Submitted in writing and delivered live on October 29, 2024.

Good afternoon, thank you for the opportunity to testify before you today. My name is Jesús Pérez, and I am the District Manager of Manhattan Community Board Six.

Manhattan Community Board Six strongly believes the New York State Department of Health (DOH) acted very hastily and irresponsibly in their decision to approve the closure of Mount Sinai Beth Israel (MSBI) Hospital and has not addressed the issues raised by our community. The State DOH did not fully consider the impact that approving the closure of MSBI would have on our neighbors and the district. The hospital's services are indispensable to our community, providing critical emergency care, surgery, testing, and cardiac care to thousands of residents annually. The closure would significantly impact the health and well-being of our community, particularly the elderly and vulnerable populations who rely on MSBI for access to medical services.

Over the past decade, emergency response times have increased significantly across all categories, including EMS for life-threatening situations. The heavy traffic conditions in Manhattan Community District 6 emphasize the critical importance of keeping MSBI open, as swift access to a 24-hour emergency room is vital in cases involving cardiac or stroke patients, where delays in transportation could lead to preventable loss of life.

This decision not only exacerbates health disparities but also creates additional barriers to healthcare access. The hospital's closure would force patients to travel farther for emergency care, increasing the risk of adverse health outcomes due to delayed treatment. Additionally, the closure would place an undue burden on nearby hospitals, potentially overwhelming their capacity and compromising the quality of care. This decision by the New York State Department of Health will have devastating consequences to our community, particularly for those with chronic conditions who require regular and immediate medical attention.

Thank you.

Brooklyn Perinatal Network (BPN) Inc Written Testimony

Presented to:

The New York City Council's Joint Hearing of

The Committee on Hospitals and the Committee on Health Held 10/29/24

Hearing: Oversight - Examining the Effects of Hospital Closures on Community Needs

Submitted 11/1/2024

By: Ngozi Moses, Executive Director, Brooklyn Perinatal Network

On behalf of: The Brooklyn Coalition for Health Equity for Women and Families Community Leadership Team (CLT)

Introduction

Good day, Chairperson Schulman and Members of the Health Committee. My name is Ngozi Moses, and I am here on behalf of Brooklyn Perinatal Network (BPN). Since 1988, BPN has been committed to supporting pregnant, birthing, and parenting individuals in Central and East Brooklyn, where high rates of poverty and significant health disparities contribute to some of the most challenging birth outcomes in New York City. BPN's mission is to:

1. Improve the health and well-being of individuals, children, and families through access to culturally appropriate health services.
2. Develop needed resources and address barriers to healthcare.
3. Facilitate collaboration and influence public policy to address systemic disparities.

Ongoing hospital closures, however, are undermining these objectives. They widen existing healthcare gaps, burden nearby facilities, and disproportionately harm the communities BPN serves—primarily Black, Hispanic, and immigrant populations in high-poverty areas.

Impact of Hospital Closures on Community Health Access

The closure of hospitals in Central and East Brooklyn severely disrupts healthcare access. Currently, Central Brooklyn is a designated underserved area with some of the lowest rates of primary care providers, pediatricians, and women's health specialists in New York City, putting the community at a disadvantage for both preventive and emergency care. Each closure intensifies these issues, lengthening travel times and delaying treatment, particularly for low-income families and communities of color. For example, when St. Vincent's Hospital closed in Manhattan, nearby Bellevue Hospital saw a 25-30% increase in emergency room visits, resulting in overcrowding and longer wait times.

Community Health Disparities in Central Brooklyn

Central Brooklyn faces some of the highest poverty rates in New York City, leading to elevated levels of disease and mortality. High-poverty neighborhoods like East New York, Cypress Hills, Bushwick, and Brownsville experience higher-than-average rates of chronic illness, limited healthcare access, and healthcare shortages. In 2016-2020, Black non-Hispanic women and birthing people were four times more likely to die of a pregnancy-associated cause and six times more likely to die of a pregnancy-related cause compared with white non-Hispanic women and birthing people—a disparity that hospital closures only exacerbate. https://www.nyc.gov/assets/doh/downloads/pdf/data/maternal-mortality-annual-report-2024.pdf

Hospitals' closures, is a critical healthcare provider serving a diverse and underserved population, would eliminate essential emergency, inpatient, and outpatient services. Such closures lead to:

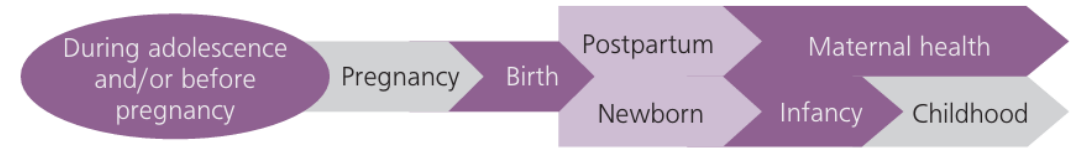
- **Increased Travel Times:** Longer distances to the nearest healthcare facility delay care, especially in emergencies, contributing to adverse health outcomes.
- **Strain on Nearby Hospitals:** Increased patient volume at surrounding hospitals leads to overcrowded facilities, longer wait times, and reduced quality of care for all patients.
- **Economic Impact:** Loss of healthcare jobs impacts the local economy, further straining families who already experience economic hardship.
- **Reduced Trust in Healthcare:** As local facilities close, community trust in the healthcare system erodes, decreasing engagement with healthcare services and worsening health outcomes.

Impact on Maternal and Child Health

Hospital closures put mothers and infants in Central and East Brooklyn at significantly increased risk. In neighborhoods where maternal mortality rates are already alarmingly high, the loss of a hospital can be life-threatening. Recently, Woodhull Medical Center saw its third maternal death since 2020. Cases like these underscores the gaps in maternal care faced by Black and immigrant women, who suffer disproportionate outcomes in emergency situations due to language barriers, inadequate response times, and limited resources.

According to the World Health Organization (WHO)report titled," Preconception Care Report Regional Expert Group Consultation" sexual and reproductive health is essential for individuals, couples, and families, as well as for the social and economic growth of communities and nations. Every person has the right to reproductive health, which serves as the foundation for having healthy children, a fulfilling reproductive life, and thriving families. Based on these agreements, a model and a package of health interventions for family planning, safe abortion care, and maternal, newborn and child health (MNCH) was developed by WHO, with inputs from the United Nations Children's Fund (UNICEF), the United Nations Population Fund (UNFPA), the World Bank and the Partnership for Maternal, Newborn and Child Health (PMNCH) (3).

Figure 2. Pre-conception care completes the coverage across the life course



https://iris.who.int/bitstream/handle/10665/205637/B5124.pdf?sequence=1&isAllowed=y

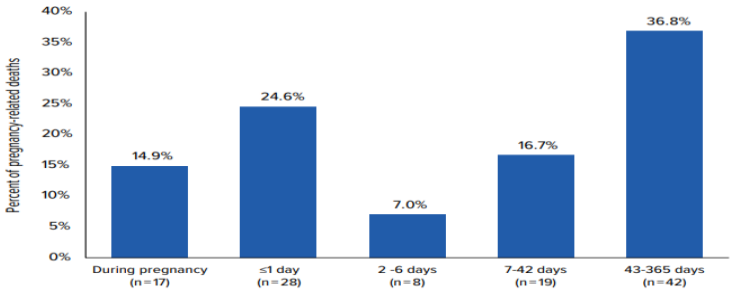
WHO further stated:

> **"There is widespread agreement that, to reduce maternal and childhood mortality, a continuum of care needs to be provided through pregnancy, childbirth, the postnatal period, infancy and childhood, adolescence and adulthood. An effective continuum of care must address the health needs of the adolescent or woman before, during and after her pregnancy, as well as the care of the newborn and child throughout the life-cycle, wherever care is provided."**

When hospitals plan closures, our communities' health care continuum, particularly women—are at heightened risk of lacking timely access to essential health care.

Furthermore, studies indicate that Black children living farther from hospitals are less likely to have regular check-ups, leading to preventable health issues. When mothers cannot access nearby prenatal and postnatal care, it raises the risk of preterm births, low birth weight, infant mortality, and death of the mother after birth. The potential closure of hospitals would limit access to vital maternal health services, increasing these risks and placing further strain on the remaining facilities.

Figure 19. Percent Distribution of Pregnancy-Related Deaths by Interval Between End of Pregnancy and Death, NYC, 2016-2020



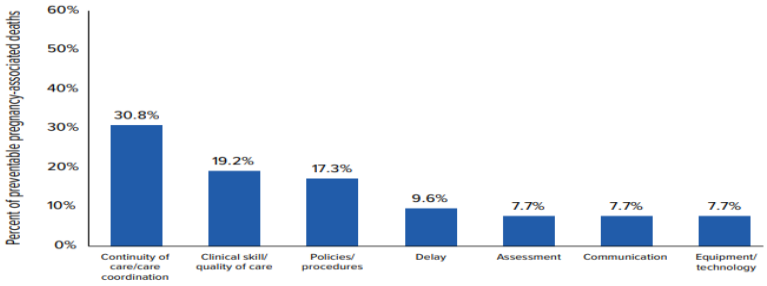
- Among all pregnancy-related deaths, 36.8% occurred 43 to 365 days after the end of pregnancy, 14.9% occurred during pregnancy and 24.6% occurred within one day after the end of pregnancy.

https://www.nyc.gov/assets/doh/downloads/pdf/ms/pregnancy-associated-mortality-report-2016-2020.pdf

Challenges for Social Care Networks (SCNs) and Social Determinants of Health (SDOH)

The closure of hospitals also impacts Social Care Networks (SCNs) in Brooklyn. SCNs are critical in addressing Social Determinants of Health (SDOH), such as access to transportation, housing, and nutritious food. With hospital closure, the demand on SCNs to address these health-related social needs would increase dramatically, further stretching resources and impeding effective service delivery. The resulting challenges in coordinating care across the community will exacerbate health disparities, particularly for low-income families.

Figure 33. Facility-Level Contributing Factors Among Preventable Pregnancy-Associated Deaths, NYC, 2016-2020



- There were 52 preventable deaths identified with contributing factors at the facility level.
- Lack of continuity of care or care coordination was the top factor, contributing to 30.8% of the deaths.
- Examples of lack of continuity of care or care coordination at the facility level that contributed to these deaths include: uncoordinated care from multiple hospitals after hospital discharge; lack of provider access to full medical record; lack of chronic disease management; inadequate follow-up on mental health or substance use issues after discharge.

https://www.nyc.gov/assets/doh/downloads/pdf/ms/pregnancy-associated-mortality-report-2016-2020.pdf

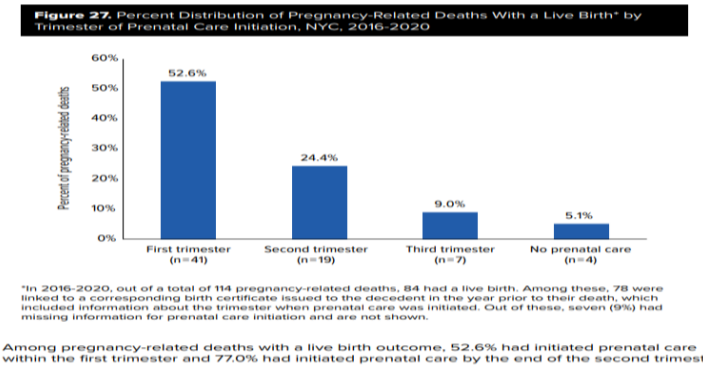
Risk of Downsizing at Downstate Health Sciences University Hospital

Brooklyn Perinatal Network (BPN) Inc Written Testimony Presented to: The New York City Council's Joint Hearing of The Committee on Hospitals and the Committee on Health Held 10/29/24
Hearing: Oversight - Examining the Effects of Hospital Closures on Community Needs
Submitted 11/1/2024 By: Ngozi Moses, Executive Director, Brooklyn Perinatal Network
On behalf of: The Brooklyn Coalition for Health Equity for Women and Families Community Leadership Team (CLT)

In addition to potential closures, the recent proposal by NYS Governor Hochul, submitted by SUNY Chancellor King, to resize Downstate Health Sciences University Hospital and convert it into an ambulatory site would further reduce primary care access by eliminating its clinical component. This transition threatens to disrupt our community's healthcare ecosystem, diminishing both access and quality and stripping away essential clinical services that our residents depend on. For Central and East Brooklyn—already facing some of the lowest ratios of healthcare providers to residents—such a loss would only deepen existing inequities.

Examples from Other Closures in New York and Beyond

Hospital closures have left devastating impacts in urban centers like New York City and Philadelphia. The closure of Hahnemann University Hospital in Philadelphia led to a 40% increase in ambulance arrivals at Thomas Jefferson University Hospital, creating severe delays and backlogs. These cases serve as a warning for Central and East Brooklyn, where our residents cannot afford further reductions in healthcare access. The anticipated impacts of hospital closures in our neighborhoods include longer travel times, increased emergency response times, and deteriorating health outcomes, especially for Black and Hispanic populations.



https://www.nyc.gov/assets/doh/downloads/pdf/ms/pregnancy-associated-mortality-report-2016-2020.pdf

Current Interventions and Their Limitations

BPN acknowledges NYC Health + Hospitals' recent initiatives to improve maternal healthcare, such as the establishment of simulation labs for obstetric training and the $11 million investment by Brooklyn Borough President Antonio Reynoso to improve Woodhull Medical Center's maternity services. While these investments are crucial, they do not fill the void created by hospital closures. Reducing accessibility to critical resources compromises the continuity of care and worsens outcomes, underscoring the need for more comprehensive solutions to protect healthcare access in underserved areas.

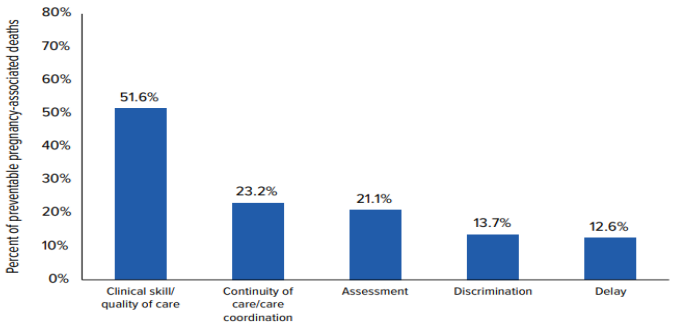
Loss of Critical Services in East Flatbush

The recent reduction of services at Kingsbrook Jewish Medical Center serves as a stark example of the impact of hospital closures on Central Brooklyn. Kingsbrook's decision to discontinue emergency, rehabilitation, and dialysis services forces East Flatbush residents to seek care farther away, putting patient lives at risk and exacerbating the healthcare strain in neighboring communities. Each reduction signifies a larger pattern of disinvestment in low-income and communities of color, leaving residents without accessible, reliable healthcare options.

Structural Racism and Health Disparities

The trend of hospital closures in Black neighborhoods is the result of systemic inequities and structural racism. When healthcare facilities are removed from communities already facing significant barriers, it places an unequal burden on Black and Hispanic populations, limiting their access to preventive and emergency care. BPN calls for immediate policy action to protect and support healthcare access in these neighborhoods, as the health and future of our communities remain at risk without it.

Figure 32. Provider-Level Contributing Factors Among Preventable Pregnancy-Associated Deaths, NYC, 2016-2020



- There were 95 preventable deaths with contributing factors at the provider level.
- Clinical skill/quality of care was a contributing factor in half (51.6%) of these 95 preventable deaths.
- Examples of clinical skill/quality of care issues at the provider level that contributed to these deaths include: failure to recognize signs and symptoms of pulmonary embolism; delay of timing of interventions (transfusion, hysterectomy); multiple negative interactions with medical staff, reinforcing barriers to accessing care; neglect of woman or birthing person's symptoms.
- The percentage of cases where discrimination was identified could be an underestimate as this was only added as a factor in May 2020.

https://www.nyc.gov/assets/doh/downloads/pdf/ms/pregnancy-associated-mortality-report-2016-2020.pdf

Conclusion and Policy Recommendations

Hospital closures in Central and East Brooklyn have a profound and lasting impact on maternal and child health outcomes, deepening existing disparities and widening healthcare access gaps. Brooklyn Perinatal Network urges the New York City Council Health Committee to take decisive action, prioritizing funding and policies that protect healthcare access in underserved areas. A comprehensive, sustained approach is essential to prevent further closures and to support the health and well-being of families in Central and East Brooklyn.

Our families deserve equitable access to quality healthcare. We must not allow disinvestment to continue eroding health outcomes in Central and East Brooklyn. BPN stands ready to collaborate with the Council and our partners to ensure that every resident has the resources they need for a healthy future.

Thank you for your time and consideration. BPN is committed to advocating for the healthcare needs of our community and looks forward to working together to build a stronger, healthier Brooklyn.

Ngozi Moses

Ngozi

Executive Director

Brooklyn Perinatal Network

Acknowledgements and Related Recommended Reading

1. https://www.nyc.gov/site/doh/data/data-sets/maternal-morbidity-mortality-surveillance.page
2. https://www.health.ny.gov/health_care/medicaid/redesign/sdh/scn/index.htm
3. https://www.nyc.gov/assets/doh/downloads/pdf/ms/pregnancy-associated-mortality-report-2016-2020.pdf

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8. Kaufman, M. (2023). *Brooklyn safety-net hospital slated for more cuts*. Politico. Link.

Contributors to this document:

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CENTER FOR INDEPENDENCE OF THE DISABLED, NY

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The Effects of Hospital Closures on Community Needs

10/29/2024

My name is Mbacke Thiam. I am the Housing, Health, and CAN Community Organizer at the Center for Independence of the Disabled, New York (CIDNY). We are a nonprofit organization founded in 1978. We are part of the Independent Living Centers movement, a national network of grassroots and community-based organizations that enhance opportunities for people with disabilities to direct their own lives. CIDNY advocates for people with disabilities in the five boroughs of New York City.

Today, I am here to testify on behalf of CIDNY regarding the detrimental effects of hospital closure on people with disabilities and their families. In the five boroughs of New York City, many hospitals are entirely or partially closing their facilities without patients' input or consideration.

In November of 2023, Kingsbrook Hospital closed its Emergency Room along with interrupting/terminating many services:

- Emergency Room Services
- Inpatient Psychiatry Beds
- Inpatient Physical Medicine and Rehabilitation Beds
- Hyperbaric Chamber Oxygen Therapy
- Dialysis Services for non-Rutland Nursing Home residents
- Ambulatory Surgery
- Designated AID Center

In March of 2024, Mount Sinai began to close facilities, stopped providing services, and planned to entirely and permanently close Beth Israel Hospital in July of 2024 without a "**fair and independent**" **Health Equity Impact Assessment** S1451A/A191. This legislation "relates to requiring a health equity assessment to be filed with an application for construction or change to a hospital or health related services." The so-called assessment Mount Sinai processed was not inclusive of people with disabilities and elderly patients. A prime example of this fact is a wheelchair user named Dustin Jones, who said, "After being a patient with them since 2015 and not having a clear understanding of what was going to happen with my healthcare, I felt like I was forced to switch my primary care services from Beth Israel. However, because of the switch, the only other place that could accommodate me was NYU Brooklyn, about 30 minutes away from my house by train and one bus on a good day vs a 15-minute walk/wheel to Beth Israel Mount Sinai. Imagine what would happen if the elevators at the train stations are not working in some days."

On July 26th, 2024, marks the 34th anniversary of the Americans with Disabilities Act. Adding insult to injury, which is the date the Department of Health chose to approve Mount Sinai's

closure of Beth Israel, under conditions to ensure that other nearby hospitals can take care of the patients: **Urgent Care Center, Bellevue Hospital expansion, other hospital agreements, Fire Department collaboration, etc.**

As a member of Save Beth Israel and New York Eye & Ear Infirmary (NYEEI), CIDNY will keep fighting and believing that we can keep Beth Israel open and fully operating, since we worked with NYS legislators and passed the Local Input in Community Healthcare Act (S8843A/A1633B). This legislation "requires public notice and public engagement when a general hospital seeks to close entirely or (partially) any unit that provides maternity, mental health or substance use care." We hereby urge Governor Kathy Hochul to sign this legislation into law and stop Mount Sinai from closing Beth Israel.

Let us remember that Mount Sinai planned to close NYEEI a couple of years ago. Thanks to our advocacy efforts, they backed out of that plan. Today, we advocate keeping NYEEI open and operating, as a landmark decision in protecting the quality of our healthcare system.

We need to combine our efforts at the City and State levels to keep Beth Israel open and operating. We can do this together. Additionally, I will use the example of SUNY Downstate, which was saved from closing by Governor Kathy Hochul's providing $300 million in capital funding and up to $100 million for operations until April of 2025.

CIDNY supports:

- Res 0022-2024: Resolution calling on the Mount Sinai Health System to keep the 16th Street Mount Sinai Beth Israel hospital campus open.
- Res 0023-2024: Resolution calling on the New York State to prevent the Mount Sinai Health System from closing the 16th Street Mount Sinai Beth Israel hospital campus.
- Res 0339-2024: Resolution calling on the New York State Legislature to Pass, and the Governor to sign the Local Input in Community Healthcare Act (S8843A/A1633B).

  This testimony is supported by Sharon McLennon Wier, Ph.D., MSEd., CRC, LMHC, Executive Director of CIDNY.

Thank you,

Mbacke Thiam, He/him/his
Housing, Health & CAN Community Organizer
Center for Independence of the Disabled, NY (CIDNY)

New York City Council's Committees on Hospitals and Health
New York City Council Hearing: Examining the Effects of Hospital Closures on Community Needs
October 29, 2024

Background

The Community Health Care Association of New York State (CHCANYS) is appreciative of the opportunity to provide written testimony to NYC Council Committees on Hospitals and Health on the critical need to strengthen primary care amidst ongoing hospital closures impacting NYC. CHCANYS is the statewide primary care association representing New York's 70+ federally qualified health centers (FQHCs), also known as community health centers (CHCs).

Community health centers are the healthcare lifeline for NYC's medically underserved communities, ensuring essential primary and preventive care for all New Yorkers—regardless of their ability to pay, insurance coverage, or immigration status. Additionally, CHCs go beyond providing quality primary and preventive care—they offer comprehensive enrollment support to help patients access services they're eligible for. While CHCs do not record immigration status, it is highly likely that many uninsured patients, including asylum seekers, are unable to obtain coverage due to their immigration status or lack of necessary documentation.

Across 490 sites in the five boroughs, these CHCs are the city's primary care safety net, serving more than 1.3 million patients. In a city of profound diversity and inequality, 92% of CHC patients live below 200% of the federal poverty level, 81% are Black, Indigenous, or People of Color (BIPOC), 31% speak limited or no English, 12% are uninsured, 5% are unhoused, and 70% depend on Medicaid, CHIP, or are dually enrolled in Medicare and Medicaid.

CHCANYS calls on the NYC Council to make a critical investment in primary care and strengthen the primary care workforce, particularly for CHCs that serve and are trusted by the city's most vulnerable populations. With hospital closures increasingly limiting access to care, bolstering primary care is not just urgent—it is essential to safeguarding the health of these communities and ensuring they receive the care they deserve.

I. Investing in Primary Care & CHCs = Investing in a Healthier New York

a. Strengthen NYC's Primary Care Foundation

The trend of hospital closures presents significant challenges and barriers to accessing healthcare for communities across NYC, especially for the medically underserved. It underscores the need to strengthen and invest in primary care as the foundation of our healthcare system. Primary care plays a crucial role in identifying and addressing health issues early, often before they escalate into more serious conditions requiring costly and intensive hospital or specialty care.

Primary care providers (PCPs) foster ongoing relationships with patients, often becoming trusted sources of care. This rapport enables them to monitor health effectively, catch warning signs early, and proactively manage chronic conditions. Routine check-ups, screenings, and preventive measures allow providers to intervene when issues are still manageable, thereby reducing the risk of complications.

Access to consistent primary care empowers individuals to seek help before their symptoms worsen, fostering a proactive approach to health.

Without access to consistent primary care, however, many people tend to seek help only when their symptoms become severe, often leading to emergency room visits or hospitalization. Strengthening primary care alleviates pressure on the healthcare system by helping individuals maintain their health over time, thus reducing the need for costly interventions. It also has the potential to ease the current healthcare workforce shortage crisis while ensuring a more balanced distribution of resources across the healthcare system.

CHCANYS respectfully requests the NYC Council to make targeted investments in primary care for underserved communities, particularly those served by CHCs. While primary care is the cornerstone of our healthcare system, it has been historically underfunded, representing only about 5-7% of total healthcare spending despite accounting for roughly 35% of all health visits each year.[1][2] Primary investments must focus on enhancing access to screenings, delivering essential health education, and implementing initiatives to reduce maternal mortality and improve maternal health outcomes. The Council should also consider targeting initiatives to underserved and BIPOC communities to advance health equity and address inequities. By treating small issues early, primary care helps people avoid major health crises down the road.

b. Investing in Community Health Centers is Investing in Healthier Communities

As NYC's primary care safety net, CHCs play a key role in advancing health equity and mitigating disparities, especially amidst hospital closures affecting communities across the city. Research shows that by July 2021, while 40% of COVID vaccines were administered to people of color in the general US population, CHCs administered an impressive 61.4% of their COVID vaccines to this population.[3] This reflects the intentional placement of CHCs in underserved neighborhoods and the trust they have built within their communities, making them essential to initiatives aimed at improving health outcomes.

There are, however, significant financial challenges that are threatening CHCs' ability to deliver life-saving care. Elevating investments in primary care is central to building a robust and sustainable workforce equipped to meet the growing demand for primary care services. Supporting CHCs is not only critical for addressing the healthcare workforce crisis, but also for providing primary and preventive care that reduces reliance on hospital care like emergency room visits and specialty care.

Analysis by the Urban Institute revealed that CHC costs are 44% higher than the maximum allowable CHC Medicaid rate, driven by rising operating expenses related to personnel, benefits, equipment, and office space – costs that have only surged further.[4] Increased investments in CHCs would enable them to enhance recruitment and retention efforts, allowing for the creation of more attractive benefits packages and competitive compensation. In this way, NYC can protect the essential role CHCs play in ensuring that all New Yorkers have access to the care they need, especially in these challenging times.

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[1] https://archive.thepcc.org/sites/default/files/resources/pcmh_evidence_report_2019_0.pdf
[2] https://www.nationalacademies.org/our-work/implementing-high-quality-primary-care#sectionPublications
[3] Assessment of Administration and Receipt of COVID-19 Vaccines by Race and Ethnicity in US Federally Qualified Health Centers | Health Policy | JAMA Network Open | JAMA Network
[4] Critical Role of New York's Community Health Centers in Advancing Equity in Medicaid | Urban Institute

In addition, CHCANYS greatly appreciates the NYC Council's enactment of legislation (INT.1668-A) on October 10, 2021, to enroll CHCs into the NYC Care program, but its implementation is still pending. CHCANYS respectfully urges the Council to push the administration to implement the program's expansion to include CHCs, enabling funding to flow to health centers to cover the costs of care. This will support NYC CHCs' ability to provide uncompensated care, which is growing as more and more asylum seekers seek refuge and safety in NYC and are unable to access insurance, often due to lack of documentation.

II. Strengthen the Healthcare Workforce

New York City is not immune to the healthcare workforce shortage crisis that spans various provider types, with particularly acute gaps among primary care providers, nurses, behavioral health clinicians, dental professionals, medical assistants, and doulas. This issue is particularly pressing in light of hospital closures, which have heightened the urgency to strengthen the healthcare workforce, especially in primary care. The challenges in attracting students and residents to health careers—driven by factors such as high educational costs and lower compensation compared to specialized professions—compound this crisis. Moreover, insufficient staffing levels have led to increased burnout rates among existing staff, as they bear the brunt of escalating responsibilities, further complicating workforce retention efforts.

The need for significant investments is now more urgent than ever. Such investments would not only address the immediate workforce gaps but also create a sustainable pipeline for future healthcare professionals, ensuring that all New Yorkers can access essential healthcare services. Investments could include funding for existing workforce programs, developing new loan repayment programs for nursing and behavioral health staff, especially in communities of color, expanding loan repayment programs for individuals living in medically underserved communities, and increasing workforce development opportunities in medically underserved communities and communities of color.

Therefore, CHCANYS requests the Council to enhance healthcare workforce investments, with a focus on strengthening the primary care workforce. Doing so will ensure that CHCs can continue delivering quality, accessible healthcare to the 1.3 million New Yorkers across the city's five boroughs.

Conclusion

CHCANYS is thankful for the opportunity to submit this testimony to highlight the critical role of primary care and the essential role of community health centers as New York City's primary care safety net amidst hospital closures. For any questions, please contact Marie Mongeon, Vice President of Policy, mmongeon@chcanys.org.

Community Service Society

Powering a more equitable New York

President and
Chief Executive Officer
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Community Service Society of New York

Testimony before the Committee on Health and the

Committee on Hospitals

October 29, 2024

The Community Service Society of New York (CSS) would like to thank the Committees on Hospitals and the Committee on Health for holding this hearing.

CSS is a 180-year-old organization that seeks to build a more equitable New York for low- and moderate-income people. Annually, CSS helps over 130,000 New Yorkers enroll in health coverage, successfully use health insurance, resolve medical billing problems, and otherwise access care. We do this through a live-answer helpline and through our partnerships with over 50 community-based organizations working in every county of New York State. Annually, CSS and its partners save consumers over $80 million in health care costs.

Thanks to the generous support of the New York City Council, CSS coordinates the City Council-funded Managed Care Consumer Assistance Program (MCCAP), which has helped over 16,000 City residents enroll in coverage, access care, and resolve medical debt issues in partnership with 12 community-based organizations.

The majority of MCCAP clients are Medicaid recipients (40 percent), uninsured (25 percent) or Medicare recipients (15 percent). Over two-thirds of clients (67 percent) report a language other than English is spoken in the home including Spanish (34 percent), Korean (11 percent) and Polish (7 percent). Most clients (69 percent) who report race or ethnicity are New Yorkers of color. MCCAP clients are assisted with eligibility for health insurance, questions about accessing care and understanding the cost of care (41 percent). Many clients have questions about the complexity of the health care system (38 percent). MCCAP serves clients in all 5 boroughs: Queens (42 percent), Kings (19 percent), Manhattan (17 percent), Bronx (12 percent), and Staten Island (10 percent).

In the wake of the pandemic, MCCAP consumers have encountered a constantly changing landscape of health coverage and insurance eligibility rules, as well as hospital mergers and closures. MCCAP has been an invaluable resource to New Yorkers who have had to deal with complicated health care billing and access issues. We bring their insights and experiences to our testimony on the important issue before the Council today.

I. Examining the Effects of Hospital Closures on Community Needs

Since 1996, over 50 hospitals have closed statewide with more than a third of these closures taking place in New York City.[1] In the past two decades over 21,000 beds were lost across New York State (from almost 74,000 in 2003 to just 53,000 in 2020).[2] A 2024 study found that 45 percent of rural hospitals across New York State are at risk of closing in the next 2-3 years and 57 percent of rural hospitals are at risk of closing in the next 6-7 years.[3]

In June 2020, CSS issued the report *How Structural Inequalities in New York's Health Care System Exacerbate Health Disparities During the COVID-19 Pandemic: A Call for Equitable Reform.* This report documented that Black New Yorkers and other people of color had quadruple or double the COVID-19 mortality rate in the earliest days of the pandemic, when patients needed to rely on hospital-based care, when compared to White New Yorkers. This report linked the location of hospital closures to exacerbated health disparities and fatalities at the height of the COVID-19 pandemic. Hospital closures mostly occurred in poorer neighborhoods, neighborhoods where people of color live, and where there were fewer patients with health insurance or the means to pay for care. For example, the borough of Queens witnessed the closure of four safety-net hospitals (St. Joseph's in Fresh Meadows, 2004; Parkway in Forest Hills, 2008; Mary Immaculate in Jamaica, 2009; St. John's in Flushing, 2009), leaving Health + Hospitals/Elmhurst as the sole safety-net hospital serving one of the country's COVID-19 epicenters. As a result of these closures, hospital-based care is not equally, or even logically, distributed in New York State. For example, there are 1.5 beds per 1,000 people in Queens compared to 6.4 beds per 1,000 people in Manhattan.[4]

National research offers evidence that hospital closures reduce access to care, quality of care, and have negative economic impacts. As a result of hospital closures, there can be a reduction in access to emergency care at nearby hospitals,[5] decreased duration of service per patient at nearby hospitals,[6] and increased deaths from heart attacks and accidents in that community.[7] Closures are associated with a drop in quality-of-care measures,[8] increased

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[1] CSS researchers compiled press coverage of hospital closures throughout the state that took place between 1996 and 2024.

[2] Dunker, Amanda, *How Structural Inequalities In New York's Health Care System Exacerbate Health Disparities During the COVID-19 Pandemic: A Call for Equitable Reform*, June 2020, Community Service Society, https://www.cssny.org/publications/entry/how-structural-inequalities-in-new-yorks-health-care-system-exacerbate-heal.

[3] Gamble, Molly, *25 states at most risk of rural hospital closures,* Becker's Hospital Review, April 2024, https://www.beckershospitalreview.com/finance/25-states-at-most-risk-of-rural-hospital-closures.html.

[4] See n. 2, *supra.*

[5] Wishner, Jane, *A Look at Rural Hospital Closures and Implications for Access to Care: Three Case Studies,* July 2016, Kaiser Family Foundation, https://www.urban.org/sites/default/files/publication/82511/2000857-brief-a-look-at-rural-hospital-closures-and-implications-for-access-to-care.pdf.

[6] Song, Lina, *The Spillover Effects of Hospital Closures on Efficiency and Quality of Other Hospitals,* February 2023, Harvard Kennedy School, https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3318609.

[7] Buchmueller, Thomas C., *How far to the hospital: The effect of hospital closures on access to care,* July 2006, Elsevier Journal of Health Economics, https://www.sciencedirect.com/science/article/abs/pii/S0167629605001116?via%3Dihub.

[8] See n. 6, *supra.*

mortality for certain conditions,[9] and contribute to increased numbers of ED visits.[10] Hospital closures are also known to have direct negative economic impacts including job losses,[11] reducing per-capita income, and increasing unemployment.[12]

Hospital closures in New York City lend credence to these national findings. For example, after the 2010 closure of St. Vincent's in Manhattan, four nearby hospitals saw statistically significant increases in emergency department (ED), inpatient, and ambulatory care, with biggest increases for ambulatory care. The hospitals closest to St. Vincent's had the biggest increase in ED and inpatient care.[13] When EDs at Bellevue and NYU Langone Medical Center were closed following hurricane Sandy, patients were redistributed to other hospitals for emergency care. Patients of Bellevue tended to be younger, people of color, Medicaid or self-pay patients and lived outside of Manhattan. While previous patients of both closed emergency departments were redistributed to nearby hospitals, previous patients of Bellevue, a public hospital, were more likely to get care at other public hospitals even in cases when private hospitals were closer.[14]

As with the case of Beth Israel, hospital closures often ensue from mergers and acquisitions, especially in rural and underserved areas. When hospitals are acquired, units including intensive care, labor and delivery, and psychiatric care may be closed, forcing patients to travel out of their communities to access this care.[15] Further, research shows that hospital consolidation leads to layoffs of health care workers and higher prices. The increased health care spending that results from consolidation can increase costs for families, employers, states, and public programs.[16] Several studies have found an association between hospital consolidation and rising premiums.[17] Hospital consolidation has also been linked to a decrease in wages among non-health care workers with Employer Sponsored Insurance.[18]

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[9] Gujral, Kritee, *Impact of Rural and Urban Hospital Closures on Inpatient Mortality,* August 2019, National Bureau of Economic Research, https://www.nber.org/system/files/working_papers/w26182/w26182.pdf.
[10] Lee, David C., *The Impact of Hospital Closures and Hospital and Population Characteristics on Increasing Emergency Department Volume: A Geographic Analysis,* December 2015, Population Health Management, https://www.liebertpub.com/doi/10.1089/pop.2014.0123.
[11] See n. 5, *supra*.
[12] Holmes, George M., *The Effect of Rural Hospital Closures on Community Economic Health,* January 2006, Health Services Research, https://onlinelibrary.wiley.com/doi/10.1111/j.1475-6773.2005.00497.x.
[13] Garg, N. *Hospital Closure and Insights Into Patient Dispersion*, 2015, Applied Clinical Informatics, https://www.thieme-connect.de/products/ejournals/abstract/10.4338/ACI-2014-10-RA-0090.
[14] Lee, David C., *Redistribution of Emergency Department Patients After Disaster-related Closures of a Public Versus Private Hospital In New York City,* 2015, Disaster Med Public Health Prep, https://pubmed.ncbi.nlm.nih.gov/25777992/.
[15] Levinson, Zachary, *Ten Things to Know About Consolidation In Health Care Provider Markets,* KFF, April 2024, https://www.kff.org/health-costs/issue-brief/ten-things-to-know-about-consolidation-in-health-care-provider-markets/.
[16] Liu, Jodi L., *Environmental Scan on Consolidation Trends and Impacts In Health Care Markets,* RAND, September 2022, https://www.rand.org/pubs/research_reports/RRA1820-1.html.
[17] Trish, Erin E., *How do health Insurer market concentration and bargaining power with hospitals affect health Insurance premiums?,* Science Direct, July 2015, https://www.sciencedirect.com/science/article/abs/pii/S0167629615000375?via%3Dihub.
[18] Arnold, Daniel, *Who pays for health care costs?,* RAND, July 2020, https://www.rand.org/pubs/working_papers/WRA621-2.html.

Additionally, there are significant downstream effects of hospital consolidation and closures. A 2024 study on the impact of hospital consolidation found that when exposed to a one percent increase in health care prices, employers outside the health care industry reduced their payroll by over a third of one percent (0.37 percent). These results suggest that a single hospital merger can lead to $6 million in forgone wages, a $1.3 million reduction in federal income tax revenue, and job losses due to the strain high health care prices put on employers. Growing literature has documented that individuals who experience job loss can experience social consequences, increasing risk of premature mortality, particularly suicide, overdose, and liver disease. Researchers estimate that a 1 percent increase in health care prices leads to a 2.7 percent increase in deaths from suicides and overdoses, implying that approximately one in 140 individuals who become unemployed after health care prices increase die from suicide or a drug overdose.[19] Given that hospital mergers often lead to closures, and that closures further consolidate the market, is important to consider the broad economic and public health implications of hospital closures.

Both the New York City experience with prior closures and the national research literature establish that hospital closures adversely impact their communities. In the past year, Mount Sinai has proceeded with its unilateral attempt to close Beth Israel hospital in downtown Manhattan. However, this closure has been challenged and currently Beth Israel remains open and accepting patients.[20] The distribution of hospital beds in Manhattan is uneven and inequitable, while the Upper East Side is over-bedded, downtown Manhattan has far fewer beds. As Lois Uttley with the Community Voices for Health System Accountability (CVHSA) has testified, the Upper East Side has over 10 hospital beds per 1,000 people and the Lower East Side and Chinatown have less than one hospital bed per 1,000 people.[21] The City Council should pass resolutions 0022-2024 and 0023-2024 which would call on the State and Mount Sinai Health System to keep the 16th Street Mount Sinai Beth Israel hospital campus open.

II. Local Input for Community Healthcare Act

The City Council should also consider passing Resolution 0339-2024 urging Governor Hochul to sign the Local Input in Community Healthcare Act (LICH S.2085/A.1633). This bill would provide public notice and public engagement when a general hospital seeks to close or close a unit that provides maternity, mental health, or substance use care. This legislation will address gaps in the current review of proposed hospital and unit closures, making communities key stakeholders in a decision-making process.

Thank you for the opportunity to submit this testimony today. Should you have any questions, please do not hesitate to reach out to Mia Wagner at mwagner@cssny.org.

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[19] Brot-Goldberg, Zarek, *Who Pays for Rising Health Care Prices? Evidence from Hospital Mergers,* Yale Tobin Center for Economic Policy, June 2024, https://www.nber.org/papers/w32613.

[20] Goldstein, Joseph, *New York Will Allow Beth Israel Hospital to Close*, July 2024, New York Times, https://www.nytimes.com/2024/07/26/nyregion/mount-sinai-beth-israel-hospital-closure.html.

[21] See written testimony of Lois Uttley, MPP for the October 29, 2024 New York City Council Committees on Hospitals and Health public hearing on the impact of hospital closures.

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October 29, 2024 Testimony to Hospital and Civil Service and Labor Committees on Effects of Hospital Closures

The threat and actuality of hospitals closing creates ripples of uncertainty, worry, and lack of medical care for employees and patients who are in their wake. I should know, I have been through 2 hospital closures: Long Island College Hospital as well as the soon to close New York Eye and Ear Hospital.

Hospital closures negatively affect seniors, sick people, poor people and people with disabilities.

When a hospital is in the process of closing, there are fewer and fewer patients, doctors, and staff, but more and more guards! I don't know why. Do they think we're going to storm the place? At LICH, my doctor was the only person left in his whole department. When your doctor leaves, who do you see next? It will be someone who doesn't know you or your medical history. If you can find another doctor, it will likely be months before you can get an appointment. Many times the new doctor is in an office which is not wheelchair accessible or is too far away. Some patients just give up and don't get care. There doesn't seem to be any real effort to help patients in the transition.

I also worry about hospitals closing because when the next epidemic comes to New York City, where will we go?

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November 1, 2024

Lynn Schulman, Chair, Committee on Health
Mercedes Narcisse, Chair, Committee on Hospitals
New York City Council
250 Broadway
New York, NY

Re: Geographic inequity of hospitals in NYC

Dear Chairs Narcisse and Schulman:

I am an urban planner and this written testimony is in response to the hearing your committees held on October 29, 2024.

Yes, hospitals and health services are inequitably distributed in New York City
As many people pointed out during the hearing, hospitals are inequitably distributed in NYC. The Upper East Side of Manhattan, for instance, has 10.58 NYSDOH certified hospital beds per 1000 residents, while the Lower East Side has just 0.42 beds per 1000 residents. The City has 2.74 beds per 1000 residents, but the entire Borough of Queens has just 1.65 and Brooklyn has 2.09. Hospital bed distribution does not reflect the City's population distribution.

Your hearing was primarily about hospital closures, but if we are concerned about geographic equity in hospitals, there needs to also be a discussion on hospital *openings* as well. Closures and openings are the two sides to geographic inequity. The closure of hospitals in underserved areas and the opening of hospitals in overserved areas create geographic inequity. The number of hospital beds in any metropolitan area are largely static, relative to the total population being served. If this remains true, when we permit hospitals to create excess capacity in one area it becomes easier to close hospitals in other areas as redundant.

And for decades we've been witnessing the concentration of hospitals in limited geographic areas because that concentration benefits the hospitals and their administrators. Facilities located in "hospital districts" often find it easier to attract and retain talent when so located, and so these centralized locations are in the interests of the institutions running the facilities. If hospital locations are to be determined by the desire of hospital administrators, they will continue to concentrate in limited areas, making it easier to close hospitals outside those areas, worsening geographic inequity.

To be clear, Council itself has been contributing to this inequity by approving applications that make inequity worse. Just last month, the City Council approved an application for the expansion of Memorial Sloan Kettering, which will add 206

hospital beds to the already overserved Upper East Side.[1] There are more applications in the pipeline, including the Lenox Hill hospital application, which will add even more beds on the Upper East Side of Manhattan, making the geographic inequity that was the subject of much the testimony even worse.

Let me speak plainly: Government is facilitating the concentration of hospitals in a few neighborhoods at the expense of other neighborhoods directly through land use actions and has been doing so for generations. Through zoning, local governments can direct where hospitals open and expand. Other jurisdictions carefully plan for these expansions, but in NYC, hospitals are allowed in nearly every zoning district. NYC routinely approves hospitals anywhere administrators ask for them, as opposed to telling them where they need to go. Our refusal to plan for this land use contributes to the inequity that we're seeing, and if we continue not to plan, geographic inequity will continue to get worse.

It doesn't have to be this way

During the hearing Chair Narcisse called for a comprehensive plan to address the health needs of New York City and its hospital system. This is laudable, and I encourage the Council to work with its partners to develop such a plan, considering not only the needs of today, but for the coming generations. That said, I also encourage you not to wait for a comprehensive plan and stop approving land use applications that worsen geographic inequity. You can do that right now.

Speaker Adrienne Adams developed the City Council's Land Use Guidelines and Application Toolkit ("Guidelines") and in that document "lays out comprehensive goals for addressing citywide planning challenges."[2] One of those comprehensive goals is to:

> "proactively plan to increase access to healthcare and essential services across our neighborhoods, particularly in neighborhoods that have suffered from historic neglect or have high populations of residents with greater support needs, including seniors and those living in poverty;"

And to ensure that:

> "New development should be paired with swift and effective commitments to provide resources and support that avoids worsening inequities in communities;"[3]

[1] It also demolishes 355 units of workforce housing. The MSK approval alone will increase beds per 1000 residents on the Upper East Side to about 12.
[2] *City Council's Land Use Guidelines and Application Toolkit*, p. 1.
[3] *City Council's Land Use Guidelines and Application Toolkit*, p. 20.

The Toolkit provides a policy basis to push back and reject applications that will make health equity worse. If you care about the overconcentration of health services in some neighborhoods, which leave other neighborhoods health care deserts, you need to start making land use decisions considering health equity, which is exactly what the Guidelines demand.

For instance, on September 10, 2024, Chair Schulman questioned the applicant team for the MSK expansion regarding alternative locations in Queens or other boroughs. Such locations--literally any other location in the City--would have lessened geographic inequity by providing these cancer care services to other boroughs.

The applicant responded that they did look at locations outside Manhattan but eliminated them because the hospital would have to be bigger because the Pavilion was using hospital infrastructure provided by the neighboring Memorial Hospital. MSK representatives did not say that such a location wasn't feasible, or not desirable, just that it would have to be bigger, as the main impediment.

In my opinion, if the Council is concerned about geographic equity, the MSK response was not an acceptable answer to Council Member Schulman's questioning. We can't just focus on closures and expect to meaningfully address geographic equity. Expansions, such as MSK and the forthcoming Lenox Hill Hospital, are some of the few windows when the institutions that serve the City of New York can work to address the inequities *to which they have contributed*. Instead of further concentrating essential services on the Upper East Side, government should be insisting they find locations in underserved neighborhoods and proactively find ways to bring essential services to the communities that do not have easy access to these services.

Outside the land use process, City Council cannot force private institutions to bring their services into neighborhoods that are underserved. But inside the land use process, Council has enormous power to address this very concern.

Plans and planning matter

If land use decisions should be made "to increase access to healthcare and essential services across our neighborhoods,"[4] the City Council should make clear that all future applications that exacerbate health care inequity will be rejected. The Council may also wish to explain to DCP that it should start proactively planning for health care that addresses the City's inequities, as well as the Council's land use decision-making for all future hospital applications.

The Charter gives the Council enormous power on land use applications: the power to say no. You can demand that there will be no more business as usual and that you will no longer approve any application that worsens geographic inequity.

[4] *City Council's Land Use Guidelines and Application Toolkit*, Page 1.

You can make the recent MSK approval the last one, the inflection point, the point where geographic inequity stops getting worse because of the concentration of capacity in overserved neighborhoods. You have that power. You just have to follow your own guidelines and use it.

Close

Thank you for all you do to make New York City a better place and holding this hearing. If you have questions or would like to discuss, please feel free to contact me at george@georgejanes.com.

Sincerely,

George M. Janes, AICP
George M. Janes & Associates

Metro New York Health Care for All

Community and Labor United for Health Care Justice

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Testimony Provided to
the New York City Council at a Joint Hearing of the Committee on Hospitals and the Committee on Health
October 29, 2024

My name is Mark Hannay, and I am Director of Metro New York Health Care for All, a regional coalition of unions and community groups that advocate for universal health care and issues strategic for that goal. Two of our current projects are to coordinate the Save Beth Israel and New York Eye and Ear Campaign in Lower Manhattan, and to co-convene Community Voices for Health System Accountability, a statewide collaboration of health care advocates that strives to improve New York's oversight of hospitals and to assure access to hospital care in all communities across our state.

Before I begin my substantive remarks, I want to share my own personal story about using hospital care. I have lived in the Alphabet City part of the East Village section of Manhattan for 45 years, and the main hospital I have relied on during that time, mostly for emergency care, has been Beth Israel Medical Center. In most cases, hospitalization was not required, but in one situation, I suffered serious injuries when was sideswiped by a motor vehicle while riding my bike in midtown Manhattan and incurred a broken leg and ankle. When the ambulance picked me up, the EMTs offered me a choice of five hospitals, one of them being Beth Israel. I asked them to take me there because I consider it to be my local hospital, and I knew that if I was going to have to come and go from there for any post-hospitalization appointments, that would be the most convenient for me. I received excellent care there, and it turned out that, unbeknownst to me at the time, the hospital had one of the best orthopedic departments in the city.

All that was just before Mount Sinai took over Beth Israel and decided to sabotage and dismantle the place. Instead of investing in and supporting it, Mount Sinai chose run it into the ground for their own financial benefit and to prop up their main flagship hospital way uptown, far from Lower Manhattan. As I look at Beth Israel today, I am deeply saddened and angered by what Mount Sinai has done to it, turning one of the best and most well-regarded health care facilities in our city into a bare-bones shell of its former self, all to sell off its valuable real estate to buttress Mount Sinai's flagging investment portfolio.

Beth Israel Hospital has a long and proud history of serving Manhattan's Lower East Side, and since the closure of Cabrini Hospital in 2008, and St. Vincent's Hospital in 2010, serving as the only full-service community hospital for much of Lower Manhattan from Canal St. up to 23rd St. and from River to River. When Mount Sinai took over Beth Israel in 2013, it promised the people of Lower Manhattan that it would continue that mission, but it quickly took another direction, and no one has yet held them accountable for that.

Over the years, Beth Israel has also been a pioneer in much of what we now take for granted in terms of urban public health, immigrant health, urban family health, and serving the unique health needs of low-income people and families who live in Lower Manhattan's various public housing campuses, particularly along the East River from 14th St. down to Delancey St.

Instead, Mount Sinai has chosen to walk away from Beth Israel's tradition and history, and abandon Lower Manhattan and leave us without a community hospital. They won't even agree to continue to provide a free-standing emergency room, a top priority for our community, as Lenox Hill Hospital is successfully doing the West Village of Manhattan, and NYU Langone is doing in Cobble Hill, Brooklyn.

I'd like to now turn to the main focus of today's hearing: the impacts of hospital closures and what our city government can do to address this increasing crisis.

Thank you for holding this important hearing today to better understand the crisis of inequitable closures of hospitals and hospital units across our city, and to explore ways that City government can intervene to mitigate and end it in order to advance health equity. Health care access is not just about getting people insurance coverage, as important and necessary as that is; it is also about assuring that people have a place to go in their local community to use that coverage to receive needed care from culturally-competent providers they know and trust.

All hospitals in New York State are licensed as charitable institutions to serve their local communities and larger regions, and it is the obligation of hospital operators to figure out how to do that, in partnership with state and local governments, and to not just throw up their hands and walk away when the going gets tough or when they are tempted by the golden calf of real estate assets. We in all the various local communities across our city deeply value and rely on our local hospitals as among our most valuable and necessary community institutions – they are not just profit centers for larger ambitious hospital networks to compete against each other for market share.

While the responsibility of hospital oversight typically and historically falls under the purview of state government, in the eyes of many of us advocates, for many years now our state leaders have abdicated that obligation to represent the public interest, and ceded the matter to industry and private market forces instead. So it falls to you as our local government to step into the breach as best you can, and we urge you to seize that opportunity to be both creative and courageous. By doing so, you can challenge and

set an example for our state officials to do what they should be doing, and lead the way to try out some new ideas and show proof of concept.

Here's some ideas to consider and take up:

- Urging Gov. Kathy Hochul to sign the Local Input for Community Healthcare Act into law, as it is currently written, with no additional chapter amendments to weaken or undermine it.
- Currently, all "Full-Review" Certificate of Need proposal forms submitted by hospitals to the New York State Department of Health (DOH) provide an opportunity for comment from a local Health Systems Agency (HSA.) However, New York City has not had a functioning one for three decades. We urge the Council to resurrect and fund one, to be housed in the Department of Health and Mental Hygiene, and direct it to fulfill this role.
- Once an HSA for New York City has been revived, we urge the Council to charge it with creating a system of regional health planning for our city, so that hospital-based services and overall access to health care is evenly and equitably distributed across our city and available in all our neighborhoods, and not just areas where more affluent and well-insured people live and work. This agency should be tasked with identifying health care shortage areas and developing plans for city government to rectify that in partnership with other community stakeholders, including but not limited to hospital networks.
- All hospitals in New York City should be required to have a Community Advisory Board (CAB) to advise hospital operators and governing bodies. These boards should exist at each individual hospital within a larger hospital network and be comprised of a variety of community stakeholders. They should not just be window dressing for administrators, but active partners working with hospital leaders to undertake periodic community needs assessments, develop and implement community needs service plans, and to annually report to government agencies about the progress of those plans, as required by both the federal Affordable Care Act and IRS regulation.

In closing, we stand ready to work with the Council, the Mayor, and various city agencies not only to craft ways to appropriately respond to closures of hospitals and key hospital units, but to also think creatively and boldly about how to prevent these situations in the first place. The hospital industry can no longer be left to their own designs to sort all this out, because the record clearly shows that they cannot and will not. Government must step forward to take a hands-on active role to make sure that ALL everyday New Yorkers have access to hospital services in the communities where we live and work.

Most importantly in all these conversations and deliberations, we MUST assure equity across our city. We cannot continue to concentrate hospital-based services just on the Upper East Side of Manhattan, but they must be readily available in ALL the communities and neighborhoods across our city.

New York City Council

Testimony submitted to a joint hearing of the Committee on Hospitals and Committee on Health examining the effects of hospital closures on community needs

The impact of NYC community hospital closures on older adults

By Henry Moss, PhD,

Board Member, *New York StateWide Senior Action Council*

October 29, 2024

Nearly 20 community hospitals have closed in the five boroughs over the last 25 years, mostly in low-income, medically underserved areas, and additional facilities are in financial trouble. While there has been much discussion of how this has impacted communities generally, not enough attention has been paid to the impact on older adults, the most vulnerable of residents but also the fastest growing segment of the population. According to AARP, the 65+ population in the Bronx grew by 36% over the last decade even as 1 in 4 Bronx seniors lives in poverty. Projections show this growth accelerating through the next two decades as the huge baby boomer cohort become the oldest old (85+) starting in 2030. Projections also show a corresponding acceleration in the incidence and prevalence of disabling chronic conditions including dementia, mobility disorders, heart failure, and frailty syndrome.

As is well known, medical care expenditures nationally and locally are heavily skewed toward meeting the needs of the older population. When this population is also heavily dependent on Medicaid, the pressure on community hospital budgets can reach a critical point. Medicaid pays providers only about 70% of the cost of providing care, on average, according to an Urban Institute study of community health centers in New York. Medicare pays better but still below the cost of providing care. Such poor Medicaid reimbursement rates are a major reason for the existence of health care deserts in New York State. A number of

rural counties are federally-designated Medically Underserved Areas (MUAs) or Healthcare Provider Shortage Areas (HPSAs).

But the problem is not confined to sparsely populated upstate regions. Large segments of NYC boroughs, representing hundreds of thousands of residents, especially in Brooklyn and the Bronx, also have MUA and HPSA designations.

While community hospital closures in areas heavily dependent on Medicaid have contributed disproportionately to the creation of medically underserved areas, the impact on vulnerable older adults is particularly troubling. It means much more than having to take a subway or bus a few extra stops to another hospital or having an ambulance take one to a different ER. Here are some of the ways that seniors in these parts of New York City can be impacted.

The impact on older adults

Loss of a primary care provider: Geriatricians and geriatric nurses, and primary care practitioners generally, are hard to come by in low-income neighborhoods. Switching hospitals can sever an important primary care relationship if a provider does not have a connection to facilities outside the community or access to a medical records database. This can also affect relationships with specialists who work in the same practice.

Loss of service integration: Integrated care is especially important for seniors with multiple chronic conditions. Neighborhood hospitals often anchor a variety of associated services including clinics, urgent care centers, pharmacies, medical device outlets, behavioral health practices, including addiction treatment centers, and physical therapy offices, among other services. Local practitioners typically develop relationships with such associated services which are usually conveniently located near the hospital. This natural integration can be seriously disrupted by a closure.

Difficulties accessing specialty care: Oldest-old seniors often have multiple chronic conditions and need regular access to multiple specialists. Community hospitals have relationships with specialists who practice at the facility. When a hospital closes, specialists gravitate outside the community, often to hospitals in areas less dependent on Medicaid, setting up offices in wealthier surrounding neighborhoods.

Congestion in neighboring facilities: Many seniors use emergency rooms when experiencing exacerbations in conditions like COPD and cardiac arrhythmias, or in the event of a fall. Community hospital closures can create massive congestion and delays in nearby ERs that must accommodate displaced residents along with long waits for available beds. Long wait times are burdensome for the elderly, especially when many ERs are not well-equipped to handle elderly patients needing specialized scales and radiology stations suitable for the extremely frail. In addition, the frail elderly require much more attention from nurse aides even as many hospitals receiving displaced patients fail to maintain adequate staffing levels.

Access to social services: With more attention being paid to social determinants of health, it has become clear that seniors, especially the frail elderly, often experience social conditions that affect their physical and mental health. This includes especially the impact of social isolation and loneliness, but can also relate to problems with housing, nutrition, English language ability, and access to transportation, the internet, senior centers, and adult day facilities. Community hospitals employ social workers who help with these problems and have connections to local sources of assistance.

Deteriorating local economy: Hospitals anchor not only local medical offices and organizations, but are essential players in the broader economy. Job losses at a local hospital and in nearby ancillary services offices can devastate a community, but food service establishments that serve these workers, and other small businesses and retail outlets in the neighborhoods are also affected. This can create a vicious cycle where a loss of business vitality creates an exodus of residents to other parts of the city or region leading to a further deterioration of the local economy.

Addressing the problem

Hospitals in New York State are required to be non-profit, usually corporations with federal 501c3 tax-exempt status. In exchange for that status, hospitals must use most of their revenue in support of their community service mission and state and local governments should be providing support as needed. Government would never allow a community to lose its local high school or fire department. In the same way, it should not allow a community to lose its hospital. To prevent the

dislocation described above, we urge lawmakers and the Governor to respond accordingly:

- The Medicaid cap should be removed and cuts to the program reversed.
- Hospitals serving large numbers of Medicaid recipients should receive a greater share of available Medicaid and Disproportionate Share Hospital dollars.
- The Governor should sign into law the "Local Input for Community Healthcare" bill already passed by the legislature (S.2085/A.1633). It would strengthen the review process and assure that communities have a greater voice in decision-making.
- Legislation requiring hospitals to have a community advisory board to assist in establishing planning priorities should be passed.
- Public notice and opportunity to comment should be provided prior to state approval of any plan to close or down-size a hospital.
- The New York DOH Certificate of Need application requires input from the relevant regional Health Systems Agency (HSA). However, New York City has not had an active HSA for decades. A revitalized HSA should be formed for the entire city and housed in the Department of Health and Mental Hygiene. Its Board should include a variety of stakeholders and community representatives.
- The new HSA should inform a comprehensive research and planning process that aims to more equitably distribute resources so that distressed community hospitals with poor outcomes can receive special consideration in terms of funding, capital planning, and resource allocation.

NYLPI

JUSTICE THROUGH COMMUNITY POWER

Testimony of Noelle Peñas, Health Justice Community Organizer of New York Lawyers for the Public Interest to the New York City Council Committee on Hospitals on November 1, 2024, regarding the Oversight Hearing Examining the Effects of Hospital Closures on Community Needs

My name is Noelle Peñas, and I am the Community Organizer with the Health Justice program at New York Lawyers for the Public Interest (NYLPI). Our Health Justice program works to advance the right to health, combat the discrimination faced by immigrant New Yorkers, and to provide education to the healthcare industry. We appreciate the opportunity to provide testimony on the effects of hospital closures on community needs. As part of our Health Justice program, we advocate for equitable access to kidney transplantation developed from the experiences of our clients, many of whom face difficulty with being placed on a transplant list despite being PRUCOL (having state Medicaid or Essential Plan insurance). Hospital closures across New York City, including SUNY Downstate, would endanger the lives of Brooklyn residents, including immigrant communities.

SUNY Downstate is not just a hospital; it's a cornerstone of a largely Black, Brown, low income, and immigrant community of central Brooklyn. It provides essential healthcare services for New Yorker in a community that has been historically overburdened by high incidences of chronic disease. SUNY Downstate also houses the city's only organ transplant program within a safety net hospital, providing unparalled access to transplants to low-income, Black, and immigrant patients who have been systemically excluded from transplants by racially biased medical algorithms and decision-making models.

Many of NYLPI’s immigrant clients with renal disease are forced to depend on long-term dialysis treatments, which are debilitating, less effective, and far more expensive than kidney transplants. In 2021, NYLPI launched a pilot Transplant Pipeline with the kidney transplant program at SUNY Downstate Medical Center. This program has been transformative for a number of our clients. One of our clients, Raina (name changed) a young, Black, Caribbean, woman, had spent years believing she could not get a a kidney transplant due to her immigration status and lack of insurance. With help from volunteer lawyers working with New York Lawyers for the Public Interest, she was able to qualify for health insurance. After being denied appointments at voluntary hospitals in the city she was welcomed at SUNY has finally received a transplant. Shuttering SUNY Downstate would leave Raina and over 100 other people who are currently listed for transplants in a state of limbo and few options for care that is both as welcoming and as culturally competent as the care she receives at SUNY Downstate. For those who have received their transplants, the majority or whom are covered by public insurance like

Medicaid and the Essential Plan, connecting with the specialized medical care needed for follow-up could prove difficult given the limited uptake of such insurance at private hospitals.

SUNY Downstate is vital for ensuring that low-income communities, immigrant communities, and communities of color have fair access to life-saving kidney and other transplant screenings and surgeries. The closure of such a facility would have devastating consequences for the health and well-being of the city as a whole. We are alarmed by the proposal to restructure SUNY Downstate Medical Center, the only safety net hospital in New York City with a kidney transplantation program and the only organ transplantation program located in Brooklyn. Under this plan, SUNY Downstate would be relegated to a subsidiary role within a designated wing at Kings County Hospital Center. Such a reconfiguration could, in practice, lead to the termination of SUNY Downstate's capacity to perform transplants. The strategy threatens to compromise the fundamental mission of Downstate and inflict detrimental effects on the communities it is pledged to serve.

The proposed restructuring relies on transfer of patients to already overcrowded hospitals. This move disregards the urgent healthcare needs of city residents. It will likely exacerbate the strain on the public health system and further marginalize vulnerable populations. Furthermore, the lack of transparency and community involvement in this decision-making process is unacceptable and harmful to a large swath of our community who already face barriers to accessing lifesaving care.

Patients grappling with end-stage renal disease, including those we proudly serve, face imminent repercussions from closures of safety net hospitals. SUNY Downstate, as the sole 'public' hospital in New York offering a kidney transplant program, is an indispensable lifeline for many medically underserved New Yorkers in particular Black/African American and immigrant communities. NYLPI has documented how organ transplant listing process reveals a pattern of biased listing protocols, such as race-based algorithms, which have systematically marginalized low-income and Black/African American individuals from vital kidney transplant opportunities. It is imperative that any future strategies for SUNY Downstate incorporate robust measures to safeguard the interests of patients currently awaiting or in the process of securing a transplant.

We urge the committee to ensure that kidney transplant patients from across the city who are currently receiving care at SUNY Downstate continue to receive the lifesaving care they need without delay. SUNY Downstate represents a model of culturally competent and community centered transplant care that should be well funded and replicated across the city. By investing in this critical institution, we can strengthen our healthcare infrastructure, improve patient outcomes, and uphold our shared values of equity and compassion and continue to address the

harms that prevented the Black community, in particular, and undocumented people in general from accessing kidney transplants.

We extend deep gratitude to you, Chairperson Narcisse, and the Committee, for the opportunity to provide testimony today. We look forward to continued partnership with the City Council to advance health, immigrant, disability, and environmental justice for all New Yorkers.

Good afternoon. My name is Charline Ogbeni, and I represent Supporting Our Mothers Initiative, a cradle-to-college organization providing parenting support across New York. Today, I want to take a moment to share some remarkable stories that highlight the resilience of New York families and the unpredictable nature of childbirth.

In 2009, a baby girl was born on the B61 bus in Brooklyn, aided by a fellow passenger and the bus operator. In 2017, a subway cleaner helped deliver a baby boy at the Brooklyn Bridge station. And just this month, we celebrate the 1st birthday of BelRaye Osborne's child born on the Jackie Robinson Parkway in 2023. This week a baby was delivered on the I-990 in Niagara County, NY. These stories, and many like them make the evening news and/or the daily paper. They are a subtle reminder about how often births occur outside hospital settings.

Yet, there is rarely news about births at birth centers. Since the onset of Covid-19 it is reported that there are record numbers of families opting for out-of-hospital births with averages around 2%. Despite over 100,000 births in New York City each year, and most being uncomplicated, there is only one birth center here. Many families could benefit from this option, and it's my mission to expand access.

I have visited birth centers worldwide and seen their benefits firsthand. However, one barrier to expansion in New York is the Certificate of Need (CON) requirement. We advocate for adopting deemed status for CABC-accredited facilities to simplify the licensure process and increase accessibility.

Birth centers provide a supportive, home-like environment that prioritizes the birthing family. They offer personalized, midwife-led care focusing on physical, emotional, and cultural needs. They create a relaxed atmosphere that allows labor to progress naturally, minimizing medical interventions and reducing cesarean rates.

Birth centers also empower families, giving them autonomy over their experience, from movement options to pain management, and encouraging support from loved ones. They are a cost-effective alternative to hospitals, avoiding high intervention costs while delivering quality care. Moreover, they ensure continuity of care, building strong relationships from pregnancy through postpartum.

In Queens, my home borough, a resource like this will be groundbreaking because we don't have access to a Family Wellness Center, leading to delays in prenatal and postpartum care as well as access to critical programs that support families. Furthermore, birth centers excel in offering postpartum support. This includes comprehensive care like breastfeeding assistance, newborn care guidance, and resources for physical and emotional recovery. It's not just about the birth itself—it's about ensuring that families receive the support they need as they transition into this new phase of life.

I also aim to establish the first BIPOC-led donor milk bank in the country right here in New York City within the birth center. Families of color, who often face higher NICU admission rates, could greatly benefit from access to donor milk—an option many are unaware of. Donor breast milk

provides the perfect balance of proteins, fats, carbohydrates, vitamins, and minerals essential for an infant's growth and development. It contains all the nutrients needed to support healthy development, including the critical fatty acids that promote brain growth.

But beyond nutrition, donor milk offers powerful immunological protection. It is rich in antibodies and immune cells that help safeguard infants against infections and diseases, particularly in the early months when their immune systems are still developing. For premature or high-risk infants, this protection is especially vital. Research shows that donor milk reduces the risk of necrotizing enterocolitis (NEC), a severe and sometimes fatal intestinal disease that often affects premature babies.

We have a tremendous opportunity to invest in an alternative to hospital admissions that will directly combat the black maternal health crisis and create avenues to support the holistic health and safety of the tiniest New Yorkers. Together, we can make this a reality for families in the greatest city in the world. With your support we can make meaningful change for families today and for years to come. Thank you.

To whom it may concern,

My wife and I have been so grateful for the superb care that she has received during the several visits that we had to make to the emergency room at Mount Sinai Beth Israel. We live across the street from the hospital, and it has been so helpful and convenient for us to go there when she has been having complications during her first pregnancy. We have been impressed by the prompt treatment that we have received in the facility, which has not been overcrowded. It has made the pregnancy a significantly less stressful experience for both of us. We need a hospital in this part of the city, especially to care for the myriad individuals in the streets experiencing mental health and drug addiction crises.

We couldn't imagine having to travel over a mile during an emergency, only to wait for care in an overcrowded hospital. We also go to Mount Sinai Beth Israel for routine care and have been consistently satisfied with it and the treatment providers who we have seen. Please don't take this service, which directly contributes to our satisfactory quality of life, away from us (and as our elected officials representing us, please protect us from the greed of businesspeople and developers seeking to profit while diminishing our quality of life). Please feel free to contact me should you require any further information or testimony.

Sincerely,
Abraham E. Libman, MA

2nd Year Medical Student at Touro College of Osteopathic Medicine – Harlem Campus
Resident of: [redacted], New York, NY 10009

Dear NY City Council,

Please fight the closure of Mt Sinai Beth Israel hospital and ER – this is a lifeline for lower Manhattan, as the recent pandemic illustrated. It is the last hospital remaining in the whole of lower-east Manhattan. It appears that it has been split into real-estate holdings and the actual medical facilities, and the latter has been gutted in order to sell off the former at a huge profit. This is nothing short of corruption, and a real-estate grab. The result hurts working people who need a local ER and hospital.

Yours, Alex Barnett, [redacted], NY, NY, 10003

October 30, 2024

To the New York City Council:

A century ago, my grandmother traveled all the way from West Virginia to have surgery at Beth Israel Hospital (BI), and then in approximately 1940 successfully underwent what she was told was a ground-breaking new surgical procedure. A quarter of a century later, my grandfather expired at Beth Israel, and subsequently, my other grandmother expired at what was then a satellite of Beth Israel. I have had numerous other relatives treated there; earlier this year one with an emergent condition in great pain managed to walk to the Beth Israel Emergency Department, getting there more rapidly than via 911 given current longer response times and worsened traffic. I, too, am a patient of Beth Israel and the New York Eye and Ear Infirmary (NYEEI). And years ago, I was stationed at Beth Israel as a Mount Sinai Community Medicine resident during some of the worst years of the HIV/AIDS/tuberculosis/crack cocaine epidemic where I witnessed Beth Israel (unlike Mount Sinai, incidentally) step up to provide more than its share of care, renowned for its cutting-edge compassionate care.

It's hard to imagine the neighborhood without the essential services of Beth Israel.

As a family and preventive medicine and public health physician who practiced primary care for underserved patients over approximately a 25-year period on the Lower East Side, countless patients have relied on Beth Israel for emergency care and referral to subspecialists. Many patients have had ongoing treatment and surgical care at NYEEI. Once closed, where will patients obtain care? Bellevue and NYU-Langone Emergency Departments commonly exceed 100% occupancy, and frequently reach dangerous levels. Unimaginable wait times for a bed after admission are now routine. An urgent care center is no replacement for a full-service Emergency Department, especially when 24/7 availability is only promised for three months!

Increasing traffic and more crowded Emergency Departments have produced increasing ambulance response times, alarming enough to be the subject of a City Council hearing November 1. What looks to the State Department of Health like reasonable distances may incur travel times more consistent with nonurban areas. We need to factor in traffic at different times of day. The State Department of Health calculated travel times from Beth Israel to alternative hospitals, but patients are initially transported from their homes, not BI, and travel to more distant hospitals may turn survivable emergencies into fatal events.

According to its Administrative Record, the State Department of Health apparently expects that patients will drive themselves or hire a car service to get to alternative Emergency Departments or for urgent care services. In our community, reliance on public transportation is more typical. Patients from the easternmost areas of the Lower Side can access M14A or M14D buses to the present sites of BIU or NYEEI from relatively inaccessible areas like Grand or Delancey Streets at the FDR Drive or from Columbia Street. Patients from Chinatown can similarly reach BI or NYEEI by direct bus lines. Included are residents of numerous public housing projects, such as Smith, Rutgers, Baruch, Lillian Wald, Jacob Riis, La Guardia, Vladeck, Gompers, Meltzer Tower, First Houses, Lower East Side Houses, and Campos Plaza. Many elderly and/or disabled (including, of course, the blind and visually impaired), low-income patients cannot use the subway or are not near a subway. To get to Bellevue or NYU-Langone hospitals there is no similar single bus line from all areas that can reach alternative hospitals.

Mount Sinai has been widely condemned for its retrenchment in care for all as it has closed services, sometimes reopening them elsewhere, at great inconvenience and even danger for Lower East Side and Chinatown patients. Preceding the threatened closure–indeed, as a prelude to it–the deliberate shrinkage or relocation of Beth Israel services has already adversely affected the community. Primary and subspecialty outpatient services previously provided at the Beth Israel campus have also been lost or relocated. One of my patients from the far-eastern reaches of the Lower East Side, an elderly Spanish-dominant woman disabled by mobility limitations without relatives in New York to assist her, who formerly complied with subspecialty referrals to Mount Sinai facilities near or on 14th Street, then missed needed care for a period of years after being scheduled for 8 a.m. appointments at the main campus of Mount Sinai. When she protested she could not get to 98th Street by that time, she was told “Why don’t you take a cab?” Missed or fragmented care is dangerous and expensive.

Mount Sinai has opened concierge care in Hudson Yards, and as far afield as West Palm Beach, FL. It is pushing for a new cancer hospital only a couple of miles from Memorial Sloan-Kettering Cancer Center.

The arguments presented by Mount Sinai for the necessity of dismantling–and now destroying–the venerable and essential BI are contradictory and uncompelling. Does the fact that BI and NYEEI occupy sites that would bring enormous sums of money if sold for luxury housing play a part? Saint Vincent’s, Cabrini, Beth Israel North, and Long Island College Hospitals provide chilling parallels. Mount Sinai maintains Beth Israel is its private property, a business entity that it can close at will. But does BI manufacture widgets? Is it a restaurant or retail establishment? No! A hospital is a social good, a necessity and let’s remember, financed by *us*. Medicare and Medicaid reimbursements come from *our* tax dollars. Commercial insurance payments represent moneys contributed by working people in lieu of higher wages. Mount Sinai, allegedly non-profit with for-profit spin-offs, should not be allowed to make real estate decisions that will cost innumerable lives.

Andrea Lyman

Andrea Lyman, MD, MSc, MS

New York City Council Hospitals Committee and Health Committee Meeting on 10/29/24

Personal Testimony, Barbara Levin ([redacted], [redacted]

I am contributing my experiences as a grateful recipient of the life-saving and medical services of Beth Israel Hospital and of Manhattan Eye and Ear Hospital. My family has benefited time and time again from the LOCATION and services of these institutions. From the premature birth of my daughter to emergency surgery, sepsis, pneumonia, temporary loss of vision (to name only a few of innumerable instances), the close proximity of these hospitals and doctor's offices in frightening and urgent situations has saved at least one life and provided care in a timely manner because of their LOCATIONS and quality of care. We as a family and as a community would suffer immeasurably from the loss of these institutions.

Beth Israel operated in the black until Mount Sinai took over, with the DELIBERATE and wicked intention of driving the hospital into the red to justify shutting it down - why? For financial profit, to sell the land to real estate developers. The greed and cruelty that are depriving great swaths of the city of their community hospitals in the name of profit is simply unconscionable.

You, the City Council, are elected by the people, and tasked with maintaining the welfare of your people. Justify our trust in you. Don't allow a minority of millionaire executives to line their pockets at the expense of the health and safety of the majority of hardworking New Yorkers. Do what is right for our communities and stop the closure of essential medical services.

Sincerely,

Barbara Levin
NYCDOE Occupational Therapist, Retired
October 27, 2024

My name is Cynthia Walker, I am a Registered Nurse at SUNY Downstate Medical Center, Telemetry Unit for 19 years. I am a Union Delegate, Division Secretary, Statewide Nursing Committee member, and served as a member on the PEF Contract Team, under the leadership of President Wayne Spence, PEF Officers and Executive Board.

SUNY Downstate serves the residents of Central Brooklyn, which is the birthplace of the world renowned magnetic resonance imaging technology (MRI). SUNY Downstate is the only kidney transplant center in Brooklyn. Dedicated to delivering core services, including Level II trauma care and related services; cardiac care, maternity, pediatric, as well as emergency services, which there are more than 62,000 Brooklynites who visit the Emergency Room each year. SUNY Downstate Medical Center also serves more than 12,000 inpatient and 300,000 outpatient clients each year. SUNY Downstate has faced financial hardship due to the nature of the population it serves; including uninsured, underinsured, indigent and undocumented individuals with 20% of the population in Brooklyn living in poverty according to the US Census Bureau.

According to NYS Department of Health, the numbers of providers and staffed hospital beds are lowest in communities of color and high poverty communities due to lack of insurance and resources. The absolute number of healthcare providers who accept Medicaid is lowest in high-poverty communities and communities with high Hispanic populations.

In January 2024, plans for closure of SUNY Downstate Medical Center was announced to transfer over 300 state-operated beds and the majority of the hospital services to Kings County Medical Center and other regional healthcare facilities. Despite repeated attempts to review the written plan for closure, as well as the financial data of the hospital, no written plan or financial data was provided. There is continued effort to educate policymakers and the community about significant shortcomings of this closure, cuts in services that would affect Central Brooklyn community, and the negative impact the closure would have on the students at the SUNY Medical College. SUNY Downstate Medical College is dedicated to training a diversified healthcare workforce and is in the top 4% of schools graduating doctors and nurses in the nation, 60% are students of color.

Brooklyn Needs Downstate Coalition (composed of AFT, PEF,UUP, NYSUT, other unions, clergy, community groups and elected state representatives) is dedicated to organizing and educating residents of Brooklyn on the need to maintain and improve SUNY Downstate and will continue to educate policymakers at the state and federal levels that SUNY Downstate should be maintained and the residents of Central Brooklyn need additional investment and support. Brooklyn Needs Downstate Coalition continues to fight back against this ill-conceived closure.

SUNY Downstate Medical Center needs a long term sustainability plan and vision to develop and achieve a transparent, community-driven process that includes all affected stakeholders with the goal to guarantee the continuation of SUNY Downstate Medical Center vital contributions to the health and well-being to the residents of Central Brooklyn

Dear Councilors,

I am grateful for the City Council highlighting the closure of hospitals (10 over 20 years in Queens alone).

I have been an attending physician at Elmhurst Hospital since 2019 and was a member of the airway and resuscitation team in March/April 2020 when our hospital experienced what academics refer to as "critical care strain" – I would like the city councilors to understand what that looks like from the frontline physicians perspective.

When there are not enough nurses, doctors and frontline healthcare workers to provide intensive care, patients on ventilators suffer alone with a tube in their windpipe, secretions backing up, physically restrained to a stretcher, without sufficient pain relief or sedating medications, alarms gone unaddressed, being left to die (sometimes slowly), perhaps experiencing futile attempts at resuscitation by a damaged and demoralized team of carers unequipped with the tools and support to provide the standard they know patients receive a few miles down the road.

It is painful to write: if you were unfortunate enough to arrive at Elmhurst Hospital in March 2020 with COVID19 and you required ventilatory support, your likelihood of experiencing this approached 80%. We didn't run out of ventilators because nearly everyone on a ventilator died. Here is a second-hand story of one of those patients.

This suffering was not borne equally by all New Yorkers, rather fell disproportionately on the most voiceless – immigrants, Black people, people with limited English proficiency, essential working delivering your food – the wide disparities in COVID19 outcomes across the city were not due to patient factors but due to deliberate policy decisions to close hospitals, understaff and underfund safety net hospitals, allocating healthcare resources unevenly to the wealthiest, whitest New Yorkers and defunding everyone else.

It was amazing to me when Mount Sinai (the pass-through employer of doctors at Elmhurst Hospital, which ensures we aren't city employees and don't have city benefits/a pension) refused to pay me and my colleagues for working 90-100 hour weeks in late March 2020 when many of our colleagues were out sick with COVID19. The messaging from Mount Sinai Services was clear: we do not value you, your patients or your work - you are not essential - we will exploit your work at will and get away with it.

Mount Sinai received enormous payouts from CMS, FEMA and via the CARES Act (including a $281.7 million "employee retention credit") in 2020. Mount Sinai is currently engaged in a yearslong campaign to close Beth Israel, which will impact the already-bursting Bellevue ER and the marginalized community members who rely on it. Does Mount Sinai (along with the other large non-profit hospital systems) deserve enormous subsidies from taxpayers?

The outgoing Mount Sinai CEO (paid $70 million over his tenure) was golfing in Florida while Elmhurst Hospital healthcare workers and our patients were set up to fail by chronic understaffing.

To me it seems to make moral and financial sense for H+H to directly employ doctors, cutting out Mount Sinai Services as a pass-through HR service for Elmhurst/Queens doctors, reducing the administrative waste of duplicated HR structures and promoting accountability for H+H managers, who currently sub-contract the employment of doctors to a taxpayer-subsidized, hospital-closing health system that is not

known for its friendly employment practices. This would also make industrial activity by increasingly dismayed doctors at Elmhurst and Queens Hospitals less likely, due to the Taylor Law.

Surprisingly, Mount Sinai has degraded frontline doctors' health benefits every year since 2020. I had the misfortune to experience how bad Mount Sinai's health and disability benefits are when I was diagnosed with acute leukemia in Summer 2020 and required a bone marrow transplant. Mount Sinai sent debt collectors after me (twice) and it was striking how financially toxic such an illness could be for a full-time doctor. Luckily I am still alive and had excellent care, but I don't doubt that the hurdles placed in my way by third-party benefit administrators would have left less-privileged people (the kind who I care for every day at Elmhurst Hospital) with their care denied - all an elaborate setup by Mount Sinai and their third party benefit administrators to minimize utilization of their self-funded benefit scheme.

Since 2020 Mount Sinai Services has also cut Elmhurst doctors' sub-market pay relative to inflation, refused to provide paid parental leave exceeding state mandatory minimums, and proposed to cut our educational days. The disrespectful treatment of mission-driven doctors leads to high turnover and demoralization.

Doctors are working to reclaim our voice and seat at the table with Mount Sinai/H+H re: sufficient staffing and workforce planning for the next surge in demand – the ongoing heavy reliance on part-time, locum and high-turnover of doctors makes our system less resilient, degrades quality and safety, and wastes taxpayer money.

Hospital closures will continue apace, disparities will widen, unless elected officials and the public stand up and meaningfully address structural drivers of health inequity, demanding a more resilient and adequately staffed public health and hospital system.

Sincerely,

Dr Damien Archbold

From Dr Michelle Morse's team:

Hospital segregation, critical care strain, and inpatient mortality during the COVID-19 pandemic in New York City - PubMed

"it is important to enforce tax-exempt status for non-profit hospitals and ensure that benefits they provide for marginalized communities are commensurate to tax breaks and other government benefits received"

Consequences and causes of hospital closings – and needed action

Testimony to the New York City Council Committees on Hospitals and Health Care
Deborah Socolar, MPH
October 29, 2024

Thank you very much to the chairs and both the Hospitals Committee and Health Care Committee for taking up this important topic. My name is Deborah Socolar. I live in upper Manhattan, where I grew up. Formerly at the Boston University School of Public Health, and now independently, I'm both a researcher on health care access and costs, and an access advocate. I appreciate the opportunity to testify.

I've worked on issues of hospital closings for many years. That includes co-authoring work with Prof. Alan Sager about closings in Massachusetts, New York, and elsewhere. (I include a few examples at the end.) I've also been active in efforts to save several community hospitals – including Quincy Medical Center (2014) and Carney Hospital (2024) in my former Mass. hometowns, as well as Kingsbrook Jewish Medical Center and Beth Israel Medical Center in New York City. I speak today only for myself.

I hope that the City Council will

- ☐ pass the resolution urging the governor to sign the LICH bill, to ensure public input and strong state review of any proposed hospital closings.

- ☐ urge support for State Senator Kristen Gonzalez's bill S 8907 (which passed the Senate unanimously in June) that would: Establish "a moratorium on the closure of hospitals until the [NYS] Department of Health completes a statewide report on the aggregate impact of the closure of hospitals….[and] Requires that the report be used to designate "distressed healthcare zones," in which the Department of Health must reject any application for closure by a healthcare facility and prioritize allocations of healthcare spending."

- ☐ Pass resolutions like these that have been pending since the spring:
  - Res 0022-2024: Resolution calling on the Mount Sinai Health System to keep the 16th Street Mount Sinai Beth Israel hospital campus open.
  - Res 0023-2024: Resolution calling on the New York State to prevent the Mount Sinai Health System from closing the 16th Street Mount Sinai Beth Israel hospital campus.

The reasons for strong public action to preserve existing hospital capacity and stop closings are many. Here is some evidence and rationale on 10 points:

1. Two lessons of the pandemic:
(a) Infection control – We need more single-bed hospital rooms to reduce airborne infection risk. Dr. Abraar Karan and others have shown that COVID, which spreads by aerosols, was transmitted readily between hospital roommates separated only by a curtain. The New York State Dept. of Health has recently accepted, from some richer hospitals proposing construction, the argument that single bed rooms are now the standard of care, for infection control and other quality of care reasons. So, for example, rather than claiming that empty beds justify destroying Mount Sinai Health System hospital capacity by closing Beth Israel Hospital, Mount Sinai could use some of that facility to gain the ability to offer many more single-bed rooms in Manhattan. Rather than eliminate capacity through closings, we should protect patients in all communities

by expanding the supply of single-bed rooms (and perhaps preserve the ability to convert them back to use for 2 beds if needed for non-infectious patients).

(b) Surge capacity – The first years of the COVID-19 pandemic have made it quite obvious in New York – where many hospitals have closed in the past few decades, and where international travel and crowded living situations raise the risk of infection spread – that we need hospital surge capacity. **Let's assume that all existing hospital capacity is needed unless truly proved otherwise.** In addition to the lessons of the COVID pandemic, there is the still unpredictable threat of new COVID variants, growing disability and health crises in the wake of COVID infections, the looming risk of highly pathological avian influenza – all of which should remind us that the future is unpredictable and we need to preserve hospital surge capacity. (And since many hospitals sit on valuable sites, we need to guard against owners' possible deliberate efforts to undermine use of some facilities in order to portray them as unneeded, to get approval for selling them.) Mothballing empty beds costs little; New York State should consider creating a means of supporting hospitals in creating some mothballed capacity if they have empty units.

2. My biggest concern: When a hospital closes, evidence indicates that some patients tend to lose any connection to health care. For example, a Massachusetts study estimated that, after a closing, about 30 percent of a hospital's patient volume disappears from area hospitals, at least for a time. (Donald S. Shepard, "Estimating the Effect of Hospital Closure on Areawide Inpatient Hospital Costs," Health Services Research, Winter 1983.) In New York, appallingly, when state officials approved the proposal to close Kingsbrook 3 years ago, they ASSUMED *that some substantial share of its inpatient volume "will not materialize," vanishing from the health care system.* This should not be acceptable. Patients will suffer and die because of the disruption to their established sources of care.

Why would patients disappear from the health care system in this way? Perhaps because some people have lost their familiar, trusted point of entry to care. They may suffer greatly from their lack of easy access to other physicians and hospitals. In ethnically diverse Gloucester, Mass. for example, when residents turned out for a meeting years ago about preserving services at Addison Gilbert Hospital, many people said that they would never travel "over the bridge" to other hospitals that do not speak their language or know their community. **Built of human relationships, hospitals are not interchangeable parts.**

If Beth Israel closes, will its patients from Chinatown, for example, venture to other hospitals for care? If Downstate closes and Kings County is totally swamped, where will Downstate's patients feel comfortable to go? And even when one tries to go to another hospital, and overcomes transportation barriers, it can be very daunting to find one's way around another facility.

Regarding the NY DOH policy – in September 2020, when the Public Health and Health Planning Council reviewed the proposal to close Kingsbrook Medical Center in the heart of Brooklyn, DOH and the PHHPC accepted One Brooklyn Health's estimate that about one-third of Kingsbrook patients might go to affiliated OBH hospitals, one-third to other Brooklyn hospitals, and about one-third might "not materialize." (See, for example, p. 10-11 – https://www.health.ny.gov/facilities/public_health_and_health_planning_council/meetings/2020-09-24/docs/exhibits.pdf)

NY DOH and the PHHPC thus were endorsing a proposal that, other than noting bed numbers etc. at other facilities, had NO analysis, plan, or arrangements to ensure continued inpatient care connections or access for TWO-THIRDS of inpatient volume served at Kingsbrook – and indeed *assumed some substantial share might vanish from the health care system.* Shameful!

More briefly, on 8 other points:

3. Closing Kingsbrook was supposed to be fine with two other hospitals very nearby. Yet when I spot-check occupancy data, both Downstate and Kings County are often completely full. Last week – far from the crunch of flu season – both had only 1% of their non-ICU beds free. (https://coronavirus.health.ny.gov/hospital-bed-capacity)

4. Research on urban hospitals by my longtime colleague, Prof. Alan Sager, shows that, historically, black and poor communities have been likeliest to suffer closings. Indeed, for many decades, the single strongest predictor of which hospitals would close was the Black percentage of the population in the hospital's community – not which hospitals are unneeded, inefficient, or costly, as proponents of free market myths tend to claim.

5. After a closing, the surviving hospitals and ERs become more crowded. That affects not only people living, working, and spending time in the community where the hospital has closed, but also endangering everyone in adjacent communities. That hurts quality of care, and increases the burden on the ambulance system. It also raises the risk that patients leave without being seen (https://pubmed.ncbi.nlm.nih.gov/33845424/). So residents and elected officials for other communities have good reason to speak up against a closing across town.

6. In August, a hospital closed in my former Boston neighborhood, Dorchester. In the following weeks, local community health centers have not only had more patients, they have had to cope with many sicker, more complex patients than usual. At the nearby Codman Square Health Center, the CEO said, “Sicker patients means more time you need to spend, which means you have longer wait times in the waiting room.” He also expressed concern that “patients who would readily go to Carney are maybe deferring care due to barriers to care such as transportation or not knowing where to go.” https://baystatebanner.com/2024/10/02/health-centers-see-influx-of-patients-longer-wait-times-since-carney-closure/
https://www.dotnews.com/2024/codman-ceo-carney-s-abrupt-closure-means-people-will-die

7. New York City should gather more data on what resources are where – like inpatient rehab (consider the recent losses and current threats to units at Kingsbrook, Allen Hospital, and Beth Israel) – and what’s needed, taking a first step towards rebuilding health planning for NY City. The city should also certainly support efforts to restore health planning efforts statewide. We need forecasts of the care demand because of our aging population, potential increases in housing stock, and other factors.

8. When a hospital closes, its community tends to lose doctors, too. That compounds the disruptions to patient care. And loss of both the hospital and doctors’ offices also compound the economic hit to the neighborhood, as staff and patients and visitors/companions are no longer foot traffic for local coffee shops, pharmacies, and other stores and eateries.

9. Some said hospital mergers and closings would cut costs. But we’ve been concentrating more patients in costlier teaching hospitals – so while access declines, costs soar.

10. Please consider the evidence from the community coalition trying to save Beth Israel Medical Center. The state approval of that closing is based on very shallow analysis, which fails to account for other hospital EDs' need to serve the patients who now get admitted at BI, fails to to recognize that other EDs downtown are already over capacity, fails to address how the EMS system is running with increasing delays – and does not even to take account of traffic delays. Please act to save Beth Israel!

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I note here some examples of my work co-authored with Prof. Alan Sager at Boston University School of Public Health about hospital closings including one long report on New York, and some of our testimonies, newspaper articles, etc. which draw on our reports on Massachusetts:

Mass. Governor Should Declare a Public Health Emergency to Keep North Adams Open (2014)
https://www.bu.edu/sph/files/2010/10/Gov-should-declare-PH-emergency-to-save-NARH-26Mar14.pdf

Closing Hospitals in New York State Won't Save Money But Will Harm Access to Health Care (2006) https://www.bu.edu/sph/files/2015/05/Sager-Hospital-Closings-Short-Report-20Nov06.pdf

Identifying and Stabilizing All Needed Massachusetts Hospitals (2005)
https://www.bu.edu/sph/files/2012/07/Sager-Socolar-Hosp-stab-test-2Nov051.pdf

"Imprudent and Impatient," *Boston Sunday Globe*, 27 April 1997
https://web.archive.org/web/20100711213326/http://dccwww.bumc.bu.edu/hs/pdfs/GlobeFocusonMassclosingsApril1997.pdf

Thank you again for taking up this important issue – and thank you for the opportunity to testify.

1199SEIU
United Healthcare Workers East

Testimony of Jose Gonzalez, Member of Mt. Sinai Division, 1199 SEIU UHWE

Good Afternoon Members of the City Council,

First, I would like to thank the City Council Committee on Health and Committee on Hospitals for holding this hearing and allowing us to speak on this important issue.

My name is Jose Gonzalez, I am a member of 1199SEIU and have been an employee at Mt. Sinai Beth Israel for over 35 years. Currently, I am a Patient Billing Liaison, but over the years I have held various titles and worn many hats. Including during the COVID-19 pandemic I was working on the frontlines in materials management, ensuring we were addressing the needs of the community Beth Israel serves and providing the necessary care that carried us through that strenuous time.

I am not only here testifying as a member of 1199SEIU or an employee at Beth Israel but also as a member of the community that hospital has served. I was born and raised in Chelsea, New York City. Both of my parents have been treated in Mt. Sinai Beth Israel, my father died in hospice there, both of my in-laws work there, and both of my daughters were born there.

Hospitals are the cornerstones of our communities. Hospitals complement and amplify the efforts of the other parts of the health system. The hospitals in this city provide continuous availability of services for maternal, emergency and other complex health conditions. Our safety nets often function as some people's main form of primary care. Beyond providing direct care, hospitals are also often a significant player in local economies as a key center for job creation and career training.

Hospital staff turnover has reached record highs resulting in a national shortage of healthcare workers. At the same time, increases in chronic diseases and behavioral health conditions as well as an aging population all contribute to growing demand for care. Despite this clear demand for more resources and workers, we are seeing more and more hospital closures.

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Instead of closing hospitals, we need to improve hospital work environments, putting safety and quality first and ensuring the number of care takers in every unit of the hospital is enough to cover the number of patients in need care. Prioritizing better wages and hiring incentives are two ways we can begin to attract a larger healthcare workforce to the industry.

The possibility of a closure at Mt Sinai Beth Israel has been up in the air for years, a sad reality for many hospitals. Prior to the COVID pandemic, financial pressures on many hospitals and care facilities required them to shrink, merge or close. But following the aftermath of the pandemic, even more facilities have been unable to sustain themselves.

Hospitals matter to a community, often marking central points in our lives. They are also a fundamental part of our health systems as an instrument for care coordination and delivery. We need to take the time to explore initiatives that will effectively keep hospitals open, retain workers, and increase resources for providing care. It is imperative tthat we maintain fully functional, fully staffed, hospitals that will keep our friends, families and neighbors healthy and safe.

1199SEIU
United Healthcare Workers East

Testimony of Linda Charles, Member of RN Division, 1199 SEIU UHWE

Good Afternoon Members of the City Council,

I would like to first thank the Committee on Hospitals and Committee on Health for holding this hearing. It is imperative that we discuss the importance of keeping hospitals open in our communities and solutions for how we can continue to do so. My name is Linda Charles, and I am emergency room nurse at Mt. Sinai Beth Israel. I have been a registered nurse for 34 years and I have been at Mt. Sinai Beth Israel for over 30 years. I addition to being a nurse there, I am also a resident of the community MSBI serves.

Like Mt. Sinai Beth Israel, this city is seeing a rising number of hospitals and healthcare facilities closing. A reality no community should have to face. When a hospital closes, not only is the neighborhood it's located in impacted but the entire surrounding area and care delivery in surrounding hospitals is also negatively impacted. In the emergency at MSBI we provide care to a copious amount people, even those who reside outside of the community. In fact, I have served many Brooklyn residents in the emergency room, which is possible because of the easy accessibility to the hospital from the surrounding trains.

Mt. Sinai Beth Israel has its own pediatric and psychiatric emergency rooms that are often very busy. Removing these kinds of resources would be damaging for any community. The ability to efficiently provide care and ensure the needs of our patients are first, a hospital must be fully staffed and have the resources necessary to do so. Separate pediatric and psychiatric emergency rooms help limit wait times in the general emergency room and provide patients with a place to go based on their need. The nearest psychiatric emergency room in the surrounding is at Bellevue. Unfortunately, Bellevue treats a large amount of behavioral health patients which often causes them to go on diversion. When this happens, the remaining behavioral health patients needing care are sent to MSBI. Without another hospital with a psychiatric emergency room in the area, it will be a big hit to the community.

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As someone who lives in the area, my connection to MSBI is personal. In addition to being a nurse there, when my children were growing up, they were always treated in the pediatric emergency room. The majority of children who are in need of emergency care are in areas that do not have hospitals with a separate pediatric emergency facility. The presence of care workers who specialize in pediatrics increases pediatric readiness, which improves overall community health outcomes.

A lot of people in the community are unaware of the battle MSBI has faced regarding the hospitals' closure, which I am sure is true for many communities that experience a closure. Longstanding trends in care delivery for a community that has multiple facilities, with a variety of resources and specific emergency rooms will change with a closure of this magnitude. We need to be prioritizing maintaining our care facilities, increasing our healthcare workforce and providing the best care possible for those who need it. Closing a hospital takes away hundred, if not thousands of jobs depending on the hospitals size, it will affect healthcare outcomes in the community and put a strain on surrounding hospitals that are close enough to treat patients from that community. This will further exacerbate negative impacts for patients, especially those with accessibility issues. We need to put our consumers and communities needs first instead of prioritizing dollars and cents.

Written Testimony of Lois Uttley, MPP
New York City Council Committees on Hospitals and Health
Public Hearing on the Impact of Hospital Closures
Oct. 29, 2024

My name is Lois Uttley. I've been working with community coalitions across New York and the nation for more than 30 years to protect their access to crucial hospital services. I am co-convenor of a statewide group called Community Voices for Health System Accountability. I have a master's in public affairs and policy, teach in the Master's in Health Advocacy Program at Sarah Lawrence College and was at one time Director of Public Affairs for the NYS Department of Health.

I'm here today to warn that hospital closings are worsening already dangerous inequities in access to hospital care across our city. Medically underserved New Yorkers -- especially those who are low income, disabled, frail elderly and people of color -- are losing their trusted local hospitals. Meanwhile, big health systems are pursuing hospital expansion projects where they are *least needed*, in affluent urban and suburban neighborhoods that already have more than enough hospital capacity.

We need policymakers at the state and city levels to take action to ensure that hospital capacity is properly distributed, in places that need it most. So, I'm grateful to have the opportunity to address this critical issue today and suggest some actions you could take.

The Problem: Inequities in Access to Hospital Care

How significant are the differences among boroughs and neighborhoods in our city when it comes to hospital care? An important number to look at is this: How many hospital beds are there for every 1,000 people who live in each community?

Citywide, there are 2.7 hospital beds for every 1,000 people. That's on par with the national average. But that normal-sounding citywide average is deceptive, hiding large discrepancies within the city.

Let's look at Queens first, where our City Council Health Committee Chair Lynn Schulman lives. **Queens has only 1.65 hospital beds per 1,000 people, the lowest of any borough.** As I'm sure you are aware, Queens has lost several hospitals over the last 20 years – such as Parkway Hospital, St. John's Queens Hospital, Mary Immaculate Hospital and Peninsula Hospital.

Because of these closures, Elmhurst Hospital has had to shoulder an overwhelming burden of caring for a lot of patients – first when swine flu arrived, and then in 2020 when COVID hit hard – especially in Queens. People living in Queens were disproportionately

affected, in part because many of them were front line essential workers being exposed to COVID every day.

Let's look next at Brooklyn, our city's most populous borough and the home of City Council Hospitals Committee Chair Mercedes Narcisse, who as a nurse understands these health inequities all too well. **Brooklyn has just 2 hospital beds per every 1,000 people – somewhat better than Queens, but still well below the citywide and national averages. Brooklyn has lost Kingsbrook Jewish Medical Center and is in danger of losing SUNY Downstate.**

Staten Island is next, with 2.35 beds per 1,000 people and **the Bronx** has 2.52 beds, close to, but still less than, the citywide average. The Bronx, however, is ranked as one of the most unhealthy counties in the state, and therefore probably needs more hospital capacity.

Manhattan, by contrast, has 5.77 hospital beds per 1,000 people -- more than twice the citywide average. But even within the borough of Manhattan, there are stark disparities to hospital care, as the table below begins to demonstrate.

	2022 Population*	Hospitals	NYS DOH Beds	NYS DOH Maternity Beds	NYS DOH Certified Beds / 1000 population	NYS DOH Maternity Beds / 1000 Population
New York City	**8,467,513**	**54**	**23,225**	**1,412**	**2.74**	**0.17**
CD 108 Upper East Side	211,756	5	2,240	108	10.58	0.51
Manhattan	1,576,876	18	9,101	479	5.77	0.30
Bronx	1,424,948	9	3,597	219	2.52	0.15
Brooklyn	2,641,052	14	5,518	370	2.09	0.14
Queens	2,331,143	9	3,851	269	1.65	0.12
Staten Island	493,494	4	1,158	75	2.35	0.15

* Data Source: Community Health Profiles for 2022, Public Use Dataset, NYC Health

Let's compare two Manhattan neighborhoods – the Upper East Side and the Lower East Side. Community District 108 in the well-off and overwhelmingly white Upper East Side has an astonishing 10.58 hospital beds per 1,000 people. That's more than four times the citywide average. It's because that community district is home to five major hospitals -- NY Presbyterian/Weill Cornell, NY Presbyterian/Alexandra Cohen Hospital for Women and Newsborns, Memorial Sloan Kettering (MSK). the Hospital for Special Surgery and Lenox Hill Hospital. Two of those hospitals – MSK and Lenox Hill Hospital – are planning major expansion projects that will add even more capacity to this already well-served part of New York.

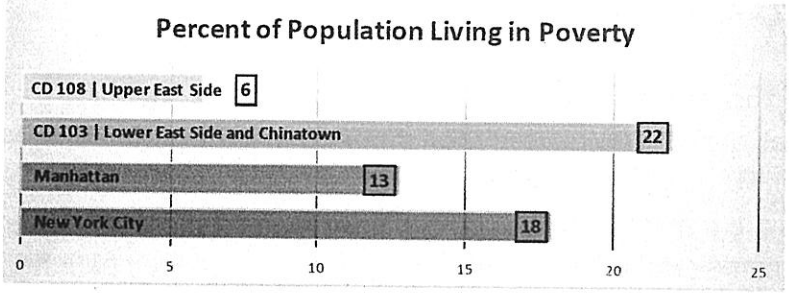
		2022 Population*	Hospitals	NYS DOH Beds	NYS DOH Maternity Beds	NYS DOH Certified Beds / 1000 population	NYS DOH Maternity Beds / 1000 Population
CD 108	Upper East Side	211,756	5	2,240	108	10.58	0.51
CD 103	Lower East Side and Chinatown	164,150	1	69	0	0.42	0.00
Borough of Manhattan		1,576,876	18	9,101	479	5.77	0.30
New York City		8,467,513	54	23,225	1,412	2.74	0.17

* Data Source: Community Health Profiles for 2022, Public Use Dataset, NYC Health

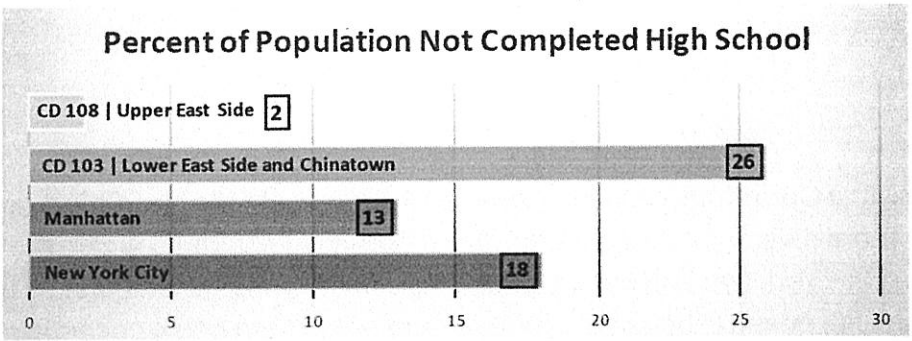
Now let's look at Community District 103 – the Lower East Side and Chinatown, a much poorer and more diverse part of our city. There is only one hospital within the Community District, the New York Eye and Ear Infirmar, a speciality hospital with just 69 beds. That works out to 0.42 hospital beds per 1,000 people – *less than half a hospital bed!*

The next closest hospital in lower Manhattan is NY Presbyterian Lower Manhattan Hospital in the financial district, with 180 beds. If we add that hospital in, and expand the geographic area we are considering, we find 0.8 hospital beds for every 1,000 people living below 14th Street in Lower Manhattan. Once upon a time, those people could turn to St. Vincent's Hospital for care, but that hospital closed. Since then, Lower Manhattan residents have come to depend on Beth Israel Medical Center as their community hospital, but that is now threatened with closure by its parent Mount Sinai Health System.

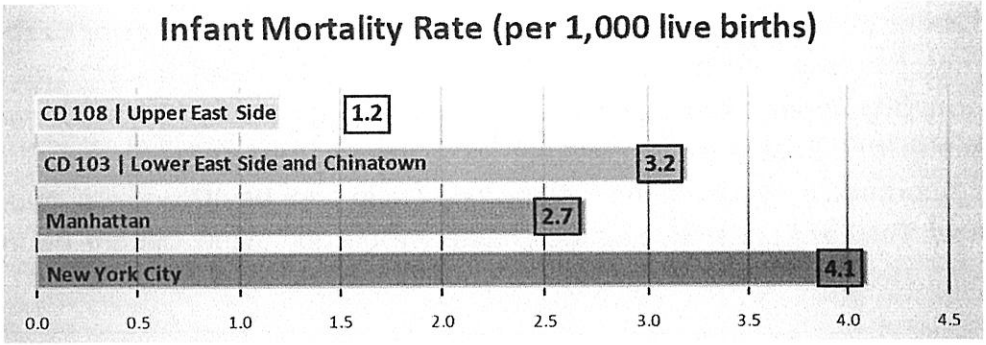
Which of these community districts – the Upper East Side or the Lower East Side/Chinatown – actually needs more hospital capacity? Let's look at some data from the New York City Department or Health and Mental Hygiene (DOHMH)'s Community District Health Profiles. The percentage of people living in poverty is one of the indicators that a neighborhood may have many people who are in poor health and are medically-underserved. The Lower East Side a much higher proportion of low-income people (22 %) compared to the Upper East Side (6 %).



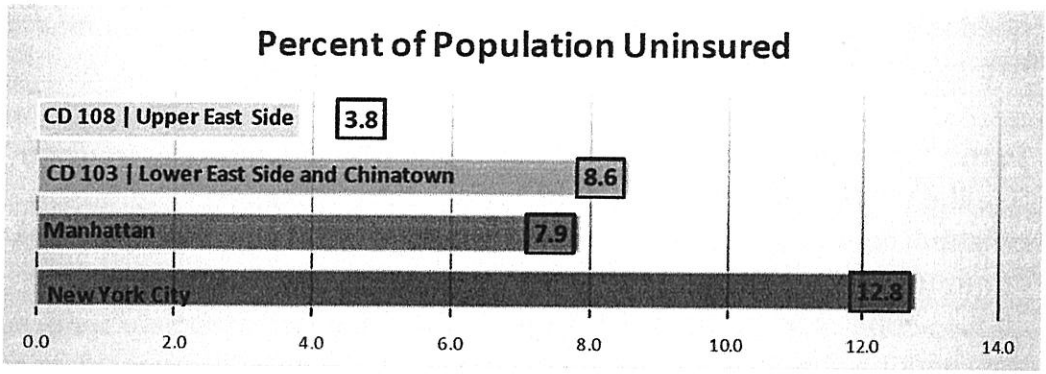
Another so-called "social determinant of health" is the educational attainment of the people living in a neighborhood. The lower the level of school completed, the higher the likelihood is that people will be unhealthy. As you can see below, 26% of people in the Lower East Side have not completed high school – more than the city-wide percentage and more than 12 times the percentage in the Upper East Side.



The DOHMH's Community Health Profiles also track important indicators of health disparities, including rates of infant mortality, avoidable adult hospitalizations and having had no or late pre-natal care. The Lower East Side has much higher rates of all these than the Upper East Side, with the infant mortality being nearly three times as high.



Finally, it's important to note that people living in the Lower East Side and Chinatown have much higher rates of being uninsured than do people in the Upper East Side, as shown in the table on the next page. No doubt that is why private health systems seeking to find insured patients are trying to flee places like the Lower East Side. But that is also why we need public policymakers to ensure that these medically-needy patients are not abandoned by our health systems!



What can we do? Some steps state and city policymakers can take

What can we do about the growing inequities in access to hospital care across New York City? Here are my suggestiions about steps that could be taken by policymakers in state and city government:

- **First, we need to urge Gov. Kathy Hochul to sign into law the Local Input for Community Healthcare (LICH) bill (S8843A/A1633B).** This measure would strengthen state oversight and ensure community engagement when hospitals are proposing to close entirely or shut key units such as maternity, emergency or mental health crisis care. This bill passed both the Senate and Assembly earlier this year and awaits the Governor's signature.

- **Next, we need to restore regional and statewide health planning and use it to inform state decisions about hospital proposals to close, downsize, expand or transfer services to another location.** Senator Kirsten Gonzalez's bill (S8907A) takes an important first step in this direction by requiring the state Department of Health to produce a report every three years describing the impact of hospital closures on access to care and identifying "distressed healthcare zones" that are at risk of future hospital closures. Distressed healthcare zones would then be prioritized when it comes to allocations of state funding and state regulatory review of proposed hospital changes.

- **New York City must actively evaluate and seek to influence state action on hospital proposals to close, downsize, expand or transfer services elsewhere across the city.** Currently, when Certificate of Need (CON) proposals to make such changes are being evaluated by the state Department of Health and the state Public Health and Health Planning Council, there is no input from the NYC DOHMH. Grassroots New York City residents are left to fend for themselves in trying to influence state decisions on such hospital transactions. That isn't right. The City Health Department must step up to the plate and weigh in to protect access to

needed hospit care for New York City residents. If legislation and funding is needed to make this happen, the City Council should advocate for it.

- **To the extent possible, the City Council and City Planning Commission should use the ULURP process to influence proposals to expand hospitals in neighborhoods where more hospital capacity is not needed, or close needed community hospitals and sell the land for real estate development.** In deciding on the scope of city review for proposed zoning changes associated with hospital transactions, the city should actively consider the potential impact on access to hospital care for medically-underserved New Yorkers.

Thank you for the opportunity present these comments. Should you want more information, please contact me at ljuttley@outlook.com

Madeline Villalba, MS-3, Gabrielle Wimer, MS-4, Zachary Gallin, MS-4
Regarding the Impacts of Hospital Closures on Community Needs
October 29, 2024

We are a group of medical students from across NYC. We are testifying on how we see hospital closures impacting communities based on our experiences caring and advocating for patients across the city, including those in the catchment areas of Beth Israel and SUNY Downstate. These impacts can be condensed into three major areas: (further) overwhelm of the public system/safety net, disruptions to access, and effects on trainees.

First, hospital closures can result in a redistribution of patients across the system that disproportionately impacts public and safety net hospitals. The major academic hospital networks in NYC service a much smaller percentage of Medicaid and uninsured patients than the public system. The impact of any closures affecting Medicaid and uninsured patients will mainly be absorbed by an overwhelmed and underfunded public system, likely worsening the quality of care at these institutions.

I (one of the contributing medical students) have spent a great deal of clerkship time in the Emergency Department of one Health and Hospitals hospital in Queens. This ED is completely full. There are sometimes beds blocking the hallways. Some patients may stay in the ED for hours or even days waiting for a hospital bed, though the ED is not a setting aligned with their acuity or care needs. Hospitals operating near, at, or over capacity are at risk of delivering poor quality care, at no fault of their own. The infrastructure simply does not exist for them to be able to absorb displaced patients. Even H+H leadership acknowledges that Kings County Hospital is “busier than it’s ever been,” and long wait times for accessing primary care have resulted in the mandated shortening of initial visit times. We cannot simply will an already overwhelmed and underfunded system to scale up immediately and deliver high quality care. The assumption that patients can simply “go to another hospital” fails to recognize that “another hospital” may be tasked with managing an unmanageable patient volume, and this can pose a threat to patients’ lives.

Additionally, while a hospital closure may superficially appear to reduce costs to the system, there is ample historical data to suggest that hospital closures don’t slow healthcare cost increases; it is likely that closures ultimately increase cost to the system as displaced patients obtain care elsewhere. Hospital closures may appear to be the result of difficulty financing an individual hospital, but they instead reflect deeper issues embedded in our system affecting the financing of the safety net in New York State. Rather than resorting to hospital closures, the city and state should work to secure and defend adequate funding for the institutions that care for those who are unable to pay, and limit the misallocation of funding directed at large hospital networks that abuse their nonprofit status at the expense of community health.

Second, hospital closures introduce major barriers to healthcare access. The closing of Beth Israel in lower Manhattan and NYC Eye and Ear Infirmary has left thousands of patients in this catchment area without a full service hospital. More horrifying is the clear evidence that Mt. Sinai deliberately chipped away at this hospital after acquiring it in 2013. SUNY Downstate holds the city's only organ transplant program within a safety net hospital, and closing this facility would exacerbate disparities in transplant access for low-income, Black, and immigrant

patients. The city and state must ensure that residents have access to the healthcare they need and must also work to curtail the actions of large hospital networks that are working counter to this goal of the public good.

There have been few studies on how communities are impacted by hospital closures, but the studies that exist all point to major disruptions in healthcare access. A JAMA study published in 1990 examined the impact of a public hospital closure in California and found that the percentage of patients who reported no regular provider nearly doubled, while the percentage who reported they were denied care increased from 10.8% to 16.9%. A 2012 study investigating the closure of St. Vincent's documented decreased access to care as well as disruptions in care for chronic conditions, and a CPHS report on the St. Vincent Community Health Needs Assessment Task Force found that Latine and African American populations had significantly greater difficulty accessing healthcare services after the closure. Access to care is a major social determinant of health. There is no question that hospital closures lead to decreased access to care, and in NYC, hospital closures occurring in medically underserved areas disproportionately affect Black and Brown communities. New York State has an admirable commitment to ensuring healthcare access for all, regardless of race, ethnicity, insurance/ability to pay, or any other characteristic. Closing hospitals recklessly, without transparency or community input, represents an egregious departure from that commitment. Healthcare system restructuring, where necessary, must promote equitable access to care and center the community.

Finally, hospital closures impact healthcare trainees who may go on to serve in the communities where they trained. For example, the proposed closing of SUNY Downstate, in a community of need, would not only impact access to tertiary services in the borough of Brooklyn, but could also impact trainees. It is unclear what will happen to the medical school and residency programs if the hospital were to close. The medical school trains a large number of students underrepresented in medicine who go on to practice in Brooklyn, and among medical schools it has one of the highest rates of graduates who practice in underserved areas. The closure would likely have downstream impacts on physician recruitment and retention in the area. Already, Health and Hospitals and other institutions struggle with adequate staffing to support the care of communities in Brooklyn and beyond; across NYC's healthcare system, Manhattan has close to 1,200 general practitioners per 100,000 people, compared to Brooklyn's 352, Queens' 366, and the Bronx's 226. The imagined "restructuring" does little to address an ongoing recruitment/staffing crisis, itself one of the underlying causes of the conditions which make hospital closures appear necessary.

Thus, we support Resolution No. 339. Communities should have a say in decisions that affect them. Community input is absolutely crucial to responding to community health needs, addressing community concerns, and better understanding how any proposed changes to hospitals affect community well-being. We also propose that the city, alongside the city health department and the state health department, more formally characterize and study the impacts of NYC hospital closures on affected communities. Finally, we recognize that hospital closures are an issue that arises downstream of structural racism, inadequate funding for the safety net, misallocation of resources intended for care of the most vulnerable, and inequitable hospital financing. We echo some of the recommendations of the Council's 2006 Task Force on Hospital Closings, chaired by Helen Sears: regular review of hospital reimbursement rates, the

development of a universal health insurance plan, and increased support for primary care infrastructure.

We are grateful to Chairs Narcisse and Schulman, Councilmember Rivera, and other members of the City Council for the opportunity to share our experiences. Your consideration is very much appreciated. As medical students, we are guided by our oaths to do no harm and to act in the name of justice. We view our testimony as an extension of what we do in the exam room. We must provide the best care possible to every patient we meet and also work to build a system that will better meet their needs and the needs of our community.

Re: hospitlal closures

I am Dr Marc Lavietes, NY resident (10013), pulmonary / critical care MD and long time health care activist.

Over the past 25 years, approximately 20 hospitals in our city have closed, with the loss of some 5,800 beds. Recent DOH data show there are 17,271 beds in our City or, on the average, approximately 2.2 beds per 1000 residents. These beds however are grossly unevenly distributed. Lower Manhattan for example has 0.8 beds /1000 people. The outer boroughs have less. By contrast given the concentration of academic hospitals in mid Manhattan, the ratio in central Manhattan approaches 10/1000. Note that in the boroughs where personal income is low and both population density and medical needs are great, hospital beds are less available. Looking back upon those hospital closures, most have occurred in the outer boroughs.

The HHC requirers a certificate of need both to construct a new hospital facility and to close one. In the past, the HHC has essentially “rubber - stamped” the demands of real estate developers for the land occupied by hospital facilities. The current issue with Beth Israel in lower Manhattan is a poignant example of a decision clearly at odds with the people’s needs. The issue of hospital closure should be examined critically by the HHC.

1199SEIU
United Healthcare Workers East

Testimony of Mark Rubin, Member of RN Division, 1199 SEIU UHWE

Good Afternoon Members of the City Council,

My name is Mark Rubin, and I am a registered nurse at Mt. Sinai Beth Israel (MSBI) and a member of 1199SEIU. I would like to thank the City Council Committees on Health and on Hospitals for holding this hearing and allowing myself, my colleagues and other necessary community voices to speak on the importance of keeping our hospitals open and running.

Currently, I am an RN in the intensive care unit and have spent the last 13 years there providing care to those that need it. MT. Sinai Beth Israel is a very large institution, in addition to being a teaching hospital, we provide care for a variety of issues including in heart disease, cancer, neurology, psychiatric disorders, and HIV/AIDS research and treatment.

As, a resident in the West Village, MSBI is also my community hospital. While I am not located very far from the hospital, my community only began utilizing MSBI as our main hospital after the closure of St. Vincents Hospital in 2010. Much like what will happen when MSBI closes, the closure of St. Vincents had a severe impact on the surrounding communities. At the time of its closure, St. Vincents was the third oldest hospital in New York City after The New York Hospital and Bellevue. It was a teaching hospital, with over 700 beds, a HIV Center and a Cancer Center, among many other comprehensive resources for the community.

In 2010, supporters of St. Vincents closing would argue that Bellevue and Mt. Sinai Beth Israel are in the area and will be able to address the need that the closure would cause. But here we are 14 years later, fighting against another closure. A closure that will have an even greater negative impact on my community.

Hospitals across New York City have continued to be under attack especially in medically underserved communities where many low income people, immigrants and people of color reside. Our safety net hospitals have continued to struggle financial and are fighting against closures, every day.

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Although MSBI is located in a neighborhood that is surrounded by some of the richest neighborhoods in the city, the comprehensive list of specialty services, pediatric and behavioral health emergency rooms and geographic location make it a hot spot for all New Yorkers to come and receive care. In intensive care, we service all kinds of people from all over this city, including those who are uninsured.

Marinating our city's hospitals and bettering our community health outcomes should be a priority for this city and this state. We cannot continue to stand by idle as we watch more hospitals close their doors. That removes necessary resources to keep our communities safe and healthy and decreases the number of jobs available in that neighborhood. The city needs to put the health and wellbeing of its constituents first and call on these large conglomerates and hospital networks to prioritize keeping hospital doors open instead of prioritizing dollars and cents.

My name is Omar Fayyaz and I was born at Beth Israel in 1987. I listened to the hearing on Tuesday and was convinced that both Mount Sinai Beth Israel and SUNY Downstate serve vital purpose in the New York City Healthcare landscape and cannot be easily substituted for or replaced.

All I have to add is that, I know it usually ends on 14th street, and that Beth Israel's maternity ward is not currently operating, but I really love being able to say I was born in the East Village and I think future generations should be able to say the same without parents needing access to a bathtub.

Rina Deych, RN

[redacted]

Brooklyn, NY 11219

[redacted]

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Every year, between the holidays of Rosh Hashana and Yom Kippur, open slaughterhouses are erected on the streets of Brooklyn for the practice of Kaporos or Kapparot. During this week, young chickens (approximately 5 – 6 weeks old) are grabbed by their fragile wings, swung around the head of the practitioner who symbolically transfers his sins into the bird then watches the chicken being killed by a ritual slaughterer, who slits the throat of the bird, then throws him or her into an inverted cone to bleed out. Since the brain stem is not cut, the petrified chicken, with his head flopping to one side, attempts in vain to fly out of the cone, only to be violently thrown back in. The chickens are then thrown into black garbage bags, many of them still alive, to bleed out and die a slow death.

The handlers of these chickens are often children between the ages of 9 and 14. During this ritual, blood, feathers, and feces flies all over the area. People bring their children of all ages, including infants, to these events.

The ritual itself is not mentioned in the Torah or Talmud and many great rabbis and sages have opposed it since the Middle Ages. The way it is practiced, in fact, violates many Jewish laws and mandates. The one work where it is discussed is 1563 Shulchan Aruch (the Code of Jewish Law), which the author Rabbi Josef Karo called it a foolish custom. He stated that a sack of money, instead of a live chicken, could be swung and then donated to the poor. Practitioners believe that the chickens' bodies are donated to charity, but in my 2 decades of studying this ritual, I have observed that many, if not most, of the chickens are thrown directly into the garbage.

In addition to breaking Jewish laws, the ritual violates 15 city and state laws. ThanNYPD has jurisdiction to shut down these illegal establishments. Religious Freedom in the First Amendment doesn't apply because that clause allows for freedom of belief, not action. In other words, people are free to believe whatever they want but actions must be within the law. We filed a FOIL request to determine the locations of the outbreak of Campylobacter a couple of years ago. The incidence of the disease, not surprisingly, was only in the neighborhoods and during the dates when Kaporos was taking place. Allowing this cruel, outdated, and unsanitary ritual to take place on public streets is exposing the general public to Campylobacter, Salmonella, E.coli, Avian Flu, and multiple other dangerous organisms.

This practice must be banned. In the very least it needs to be regulated with members of NYPD, the Department of Health, and the ASPCA monitoring these sites and issuing summonses for the multiple infractions.

Please consider taking action to put pressure on NYC officials to monitor these sites.

Please see below for the multiple laws and regulations being violated during Kaporos.

Rina Deych

Co-Founder

Alliance to End Chickens As Kaporos

LAWS AND RULES THAT ARE VIOLATED:

In addition to causing a substantial public nuisance, the fifteen known laws and/or

regulations that are violated by Kaporos are as follows:

VIOLATION OF NY AG & Mkts Law Section 5-A and 5-B

Prohibits the slaughtering of animals near residential neighborhoods, inter alia. Section 96-B makes obtaining a license to slaughter animals a requirement. No license is obtained.

VIOLATION OF NYC Administrative Code Section 18-112(d)

Prohibits the erection of a slaughterhouse on Eastern Parkway and on President Street at Kingston Avenue; provides for a prohibited zone as follows: It shall be unlawful to erect, establish or carry on, in any manner whatever, upon any lot fronting upon [locations involving the subject locations], any slaughter- house . . . or any other manufactory, trade, business or calling, which may be in anywise dangerous, obnoxious or offensive to the neighboring inhabitants. The term "slaughterhouse" is not limited to a building with walls; it includes the activity of carrying on the slaughter of animals "in any matter whatever." NYC Administrative Code § 18-112(d).

VIOLATION OF NYC Health Code section 153.09

No person shall throw or put any blood, swill, brine, offensive animal matter, noxious liquid, dead animals, offal, putrid or stinking vegetable or animal matter or other filthy matter of any kind, and no person shall allow any such matter to run or fall into any street, public place, sewer. . .

VIOLATION OF NYC Health Code section 153.21(a);

Every person who has contracted or undertaken to remove any diseased or dead animal . . . or who is engaged in such removal shall do so promptly. The operation shall be conducted in a clean and sanitary manner and shall not create any hazard to life or health. The offensive matter shall not lie piled up or partially raked together in any street or place before its removal . . .

VIOLATION OF NYC Health Code Section 161.09

Permits to keep certain animals: A permit shall not be issued for the sale or keeping for sale of live rabbits or poultry on the same lot as a multiple dwelling as defined in section 4 of the Multiple Dwelling Law or, unless the consent of the occupants is obtained, on the same lot as a two-family home. A permit shall not be issued unless the coops or runways are more than 25 feet from an inhabited

building other than a one-family home occupied by the applicant and unless the applicant submits to the Department the written consent of the owner of the lot on which the poultry or rabbits are to be kept.

VIOLATION OF NYC Health Code § 161.11

Prevention of nuisances; cleaning. (a) A permit required by § 161.09 shall not be issued unless the applicant proves to the satisfaction of the Commissioner that the place for which the application is made does not constitute a nuisance because of its proximity to a residential, business, commercial or public building, and that the place will be maintained so as not to become a nuisance. (b) Th

owner, lessee or person in charge of any place where animals are kept pursuant to a permit required by § 161.09, shall take all measures for insect and rodent control required by Article 151 and shall conduct such place so as not to create a nuisance by reason of the noise of the animals, the escape of offensive odors, or the maintenance of any condition dangerous or prejudicial to public health. (c) Every place where animals are kept pursuant to a permit required by § 161.09 shall have implements and materials, such as brooms, hoses, hose connections, vacuum cleaners where dusty conditions are found, covered metal receptacles, brushes, disinfectants and detergents, as may be required to maintain sanitary conditions. Such places shall have regularly assigned personnel to maintain sanitary conditions

VIOLATION OF NYC Health Code § 161.19

Keeping of live poultry and rabbits. (a) No person shall keep a live rooster, duck, goose or turkey in a built-up portion of the City.

VIOLATION OF NYC Health Code section 161.19(b)

Sellers of live poultry must keep the areas of slaughter and the surrounding areas clean and free of animal nuisances: person who is authorized by applicable law to keep for sale or sell livestock, live rabbits or poultry shall keep the premises in which such animals are held and slaughtered and the surrounding areas clean and free of animal nuisances. [Note, the Kaporos practitioners are not authorized to keep for sale or sell livestock, live rabbits, or poultry, but even if they were, they are violating this statute.]

VIOLATION OF 24 RCNY Section 161.03(a)

Blood and feces from animals and animal parts are prohibited on a public sidewalk and “pervasive odors” from animals are prohibited; a person who owns, possesses or controls a dog, cat or other animal shall not permit the animal to commit a nuisance on a sidewalk of any public place, on a floor, wall, stairway or roof of any public or private premises used in common by the public, or on a fence, wall or stairway of a building abutting on a public place. (includes, but is not limited to “animal feces, urine, blood, body parts, carcasses, vomit and pervasive odors; animals that carry or are ill with contagious diseases communicable to persons or other animals.

VIOLATION OF 1 NYCRR 45.4;

All persons entering any premises containing live poultry within the State of New York with any poultry truck, feed delivery and/or other service vehicle shall take every sanitary precaution possible to prevent the introduction or spread of avian influenza into or within the State. Said precautions shall include the disinfecting of all footwear before entering and after leaving any premises containing live poultry. In addition, all markets, auctions, sales outlets and distribution facilities containing live poultry shall be maintained in a clean and sanitary manner.

VIOLATION OF N.Y.S. Labor Law section 133(2)(o)

It is illegal to employ a child under the age of 18 in any slaughterhouse in any position.

VIOLATION OF NYC DEPT. OF SANITATION RULES AND REGULATIONS SECTION 16B118(6)

No swill, brine, offensive animal matter, noxious liquid or other filthy matter of any kind shall be allowed by any person to fall upon or run into any street or public place, or be taken to or put therein.

VIOLATION OF Street Activity Permit Office (SAPO) Rules and Regulations

When conducting a street activity within the boundaries of the City of New York, a permit is required. Such a permit would be required for an activity as benign as a block party. This regulation is governed by the Street Activity Permit Office (hereinafter, “SAPO”) on the New York City dot gov website. See http://www.nyc.gov/html/cecm/html/office/office.shtml.

“Religious events” are included in SAPO’s definition for permitted-required events. There is a processing fee of $25.75 and there is an insurance requirement, which gives the city an opportunity to verify that the applicant has appropriate insurance. "SAPO requires a minimum of $1M certificate of liability insurance with the City of New York listed as an additional insured for all events…" Moreover, “All street events, including block parties and street fairs, are required to recycle.”

VIOLATION OF Agriculture and Markets Law Art. 26, Section 353

A person who overdrives, overloads, tortures or cruelly beats or unjustifiably injures, maims, mutilates or kills any animal, whether wild or tame, and whether belonging to himself or to another, or deprives any animal of necessary sustenance, food or drink, or neglects or refuses to furnish it such sustenance or drink, or causes, procures or permits any animal to be overdriven, overloaded, tortured, cruelly beaten, or unjustifiably injured, maimed, mutilated or killed, or to be deprived of necessary food or drink, or who willfully sets on foot, instigates, engages in, or in any way furthers any act of cruelty to any animal, or any act tending to produce such cruelty, is guilty of a class A misdemeanor and for purposes of paragraph (b) of subdivision one of section 160.10 of the criminal procedure law, shall be treated as a misdemeanor defined in the penal law…..

VIOLATION OF NY State Agriculture and Markets Law Art. 26, Section 350 (2)

Defines “torture or cruelty” as including “every unjustifiable act, omission or neglect causing pain, suffering or death.” It also defines “animal” in section 350 (1) as including every living creature except a human being. The only statutory exemption is for use of animals in laboratories for “properly conducted scientific experiments,” and even this is closely regulated by the NYS Commissioner of Health. There is no religious exemption or exception for abusing animals for religious rituals

To Members of the City Council:

I'm a family physician with nearly 15 years of experience practicing in New York City. Most recently I have worked in NYC H+H and before that, I worked at Montefiore, NYU, and Callen Lorde community health center. I am also the vice chair of Physicians for a National Health Program Metro NY chapter.

The city must stop the continued closure of hospitals in New York City. Too many have closed in the last 20 years, in favor of real estate and other financial pressures, depriving city residents of vital services.

Poor people, people of color, and immigrants, especially those who use the public hospital system, bear the brunt of these closures and pay for them with their lives and health. Closing more hospitals only increases the widening health inequality and segregation of healthcare in New York City.

Government officials must stand up to the rampant profiteering of the real estate and health industries off of the backs of city residents. Please advocate for more health services and not fewer.

We cannot become a city of only condos for the wealthy without space and personnel to provide health services for the people.

We need a health system that eliminates the private health insurance system. Please contact state government and tell them to pass the New York Health Act to ensure high quality healthcare to all residents of NY, free at the point of service, without insurance companies, saving billions for individuals and the government.

Feel free to reach out if you would like to discuss in greater detail.

Thank you,
Roona Ray MD MPH
Queens, NY

Testimony Submitted by Sarah Batchu
In Support of Res 0339-2024

Thank you, Chair Narcisse, and my Council Member Carlina Rivera, for the opportunity to testify. My name is Sarah Batchu, and I am a public health professional and Beth Israel patient living in the East Village.

In 2021, I was making dinner with a friend when her hand slipped from the knife she was using, puncturing her palm. The injury was severe, so she called 911, and an ambulance rushed us to Mount Sinai Beth Israel, where she received immediate care. This experience underscored for me the vital role of nearby hospitals – not just urgent care, but full-scale emergency rooms for complex injuries.

This is just one of many examples of Beth Israel's lifesaving care. Yet the State Department of Health has allowed Mount Sinai to move forward with plans to close the hospital, despite clear community need. This closure reflects a disturbing trend targeting lower-income communities, worsening health inequities, and leaving neighborhoods without critical emergency and specialty care—a loss that proved deadly during the pandemic.

Decisions about hospital closures shouldn't rest solely in Albany, where industry interests often outweigh community needs. Our neighbors – older adults, people with disabilities, and low-income New Yorkers – face the greatest impact from these decisions. Patient needs must come before profit.

The proposed resolution in support of the LICH Act would help protect essential healthcare by strengthening closure reviews and integrating community input on potential closures. Passing this resolution would help ensure communities have a voice in decisions about their healthcare. Thank you all for your leadership on this issue.

The health of New York City depends on that leadership.

Oral Testimony of Stephanie H. Reckler
New York City Council Committees on Hospitals and Health
Public Hearing on the Impact of Hospital Closures
Oct. 29, 2024

Good afternoon. Thank you for the opportunity to present some comments today. I am Stephanie H. Reckler. I'm here today with a simple message: We must stop closing hospitals in medically-underserved neighborhoods, while expanding hospitals in more affluent neighborhoods that already have more than enough hospital capacity.

I have lived in the Lenox Hill neighborhood of the Upper East Side all of my life. We are fortunate to have five major hospitals close by. As you have heard in testimony from Lois Uttley, we have more than 10 hospital beds for every 1,000 residents. That is more than four times the citywide rate. Yet, it is in our neighborhood that the Northwell Health System is proposing a $1.6 billion expansion plan for Lenox Hill Hospital.

There are many reasons why I and my neighbors do not want this Lenox Hill expansion, including the prospect of 11 years of construction in a neighborhood with narrow residential streets. We also object to the enormous size of the expanded hospital, which would tower over the neighborhood.

But a more fundamental reason we oppose the Lenox Hill Hospital expansion is this: It is simply wrong to add even more hospital capacity in a neighborhood that is already extremely well-served, while people in other parts of New York City do not have enough hospital beds to meet their needs. The Lower East Side, for example, does not have enough hospital beds as it is -- and now the residents there are in serious danger of losing Beth Israel Medical Center. Queens and Brooklyn also lack enough hospital beds.

I urge the New York City Council to use every tool you have – including the city's land use review process – to prioritize hospital expansions in the neighborhoods that most need them, and discourage huge hospital expansions in already-well served neighborhoods like Lenox Hill.

Testimony for 10/29/24: Examining the Effects of Hospital Closures on Community Needs.

Hello. My name is Tyler Weaver. I was an EMT for 6 years and I'm here to discuss what affect hospital closures may have on ambulance response times, which are at record highs. These long response times tragically impacted my family in December when our adult son Nicholas Costello suffered a Cardiac Arrest in the Bronx, and waited 20 minutes for an Advanced Life Support (ALS) Paramedic-staffed unit. The backup Basic Life Support unit took 24 minutes. He was taken to the ER, but he had already suffered major brain injury, because his heart had been stopped for so long. Due to this extensive brain damage, our son was taken off life support and pronounced dead the following day. After my son died, I was so appalled at the long response time to his Cardiac Arrest, that I investigated further.

Based on what I found, I will address three main points: the disparity in ALS response times in different boroughs, more details of my son's case, and the need for more health resources in some communities.

Point 1: Bronx ALS response times are much worse than other boroughs such as Manhattan. According to official city data, only 22% of Bronx ALS responses in September arrived in less than 10 minutes. That meant 2,600 Bronx patients waited more than 10 minutes for an ALS ambulance. In contrast, the same Manhattan data was much better at 42%, and Brooklyn was 48%. This disparity has been going on for years, and it is only getting worse. This is a Health Equity issue.

Point 2: The ALS unit for my son was run by St Barnabas Hospital, but it came from 24 blocks away. The backup FDNY BLS unit was stationed 66 blocks away. This shows that Hospital-run ambulances are a crucial part of city EMS resources.

Point 3: Bronx ALS units are not resourced properly, showing there are urgent needs for improved health resources in certain communities. If a nearby Hospital is closed, ambulances would have longer travel times.

In closing, I call on the City Council, to enable EMS Health Equity in all boroughs, via more equitable budget allocation or by legislation.

Thank you for your time.

Data Addendum:

Data Table shows an an EMS Health Equity issue, comparing Bronx Advanced Life Support (ALS) Ambulance Response Times to same ALS response data for all the other boroughs, over the past three months. Historical data going back many years frequently shows a similar disparity. All data and screen shots are taken from https://www.nyc.gov/site/911reporting/reports/local-law-119-compliance.page.

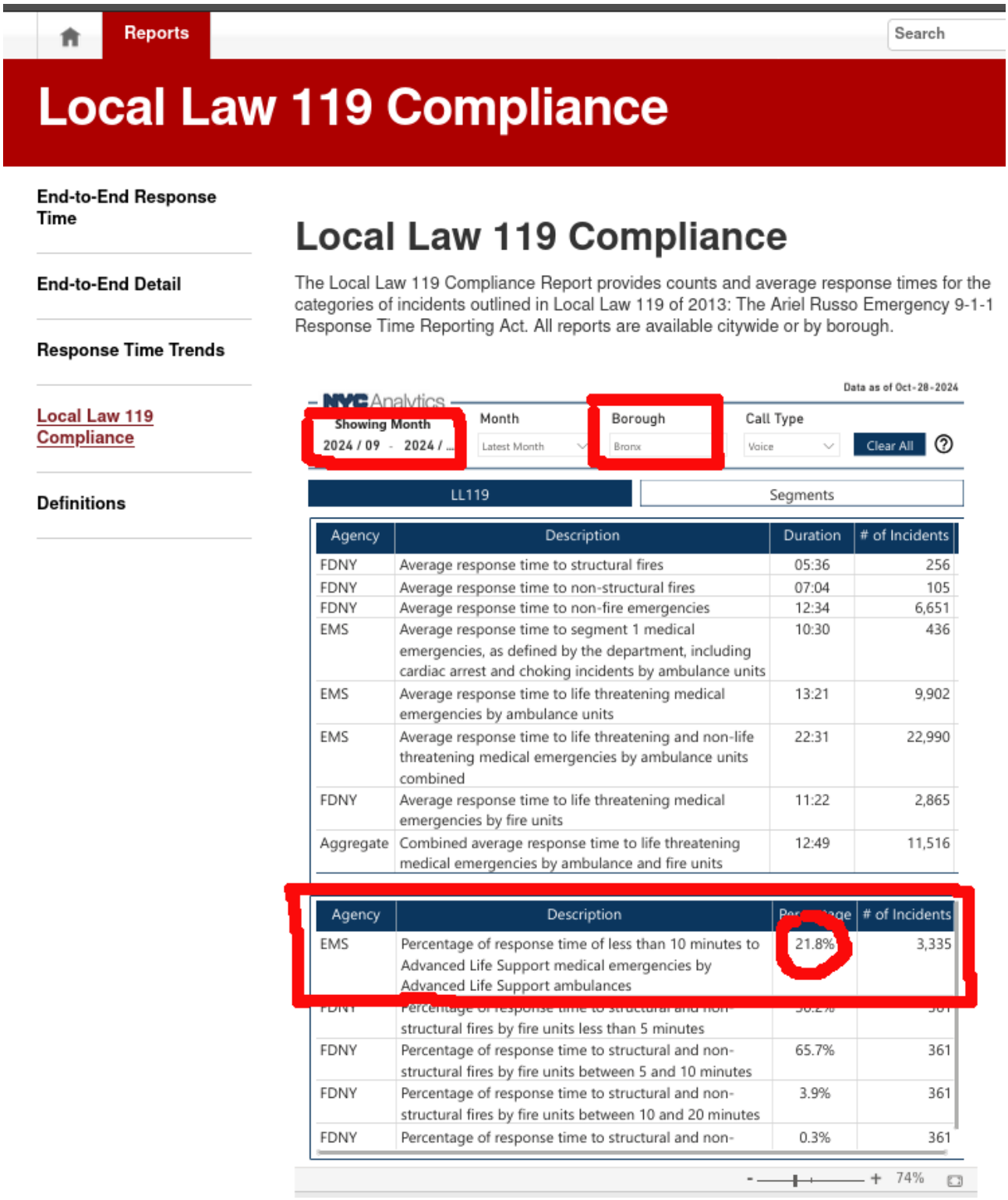
Advanced Life Support (ALS) Ambulance Response Times

Month	Bronx	Manhattan	Brooklyn	Queens	Staten Island
09/2024	22%	42%	48%	39%	48%
08/2024	26%	43%	52%	38%	57%
07/2024	25%	46%	52%	39%	53%

Percent of Responses arriving in 10 minutes or less

9/2024 Data:

Bronx – Percent of ALS Responses arriving in 10 minutes or less -



Reports

Search

Local Law 119 Compliance

End-to-End Response Time

End-to-End Detail

Response Time Trends

Local Law 119 Compliance

Definitions

Local Law 119 Compliance

The Local Law 119 Compliance Report provides counts and average response times for the categories of incidents outlined in Local Law 119 of 2013: The Ariel Russo Emergency 9-1-1 Response Time Reporting Act. All reports are available citywide or by borough.

NYC Analytics

Data as of Oct-28-2024

Showing Month: 2024 / 09 - 2024 / ...

Month: Latest Month

Borough: Bronx

Call Type: Voice

Clear All

LL119 | Segments

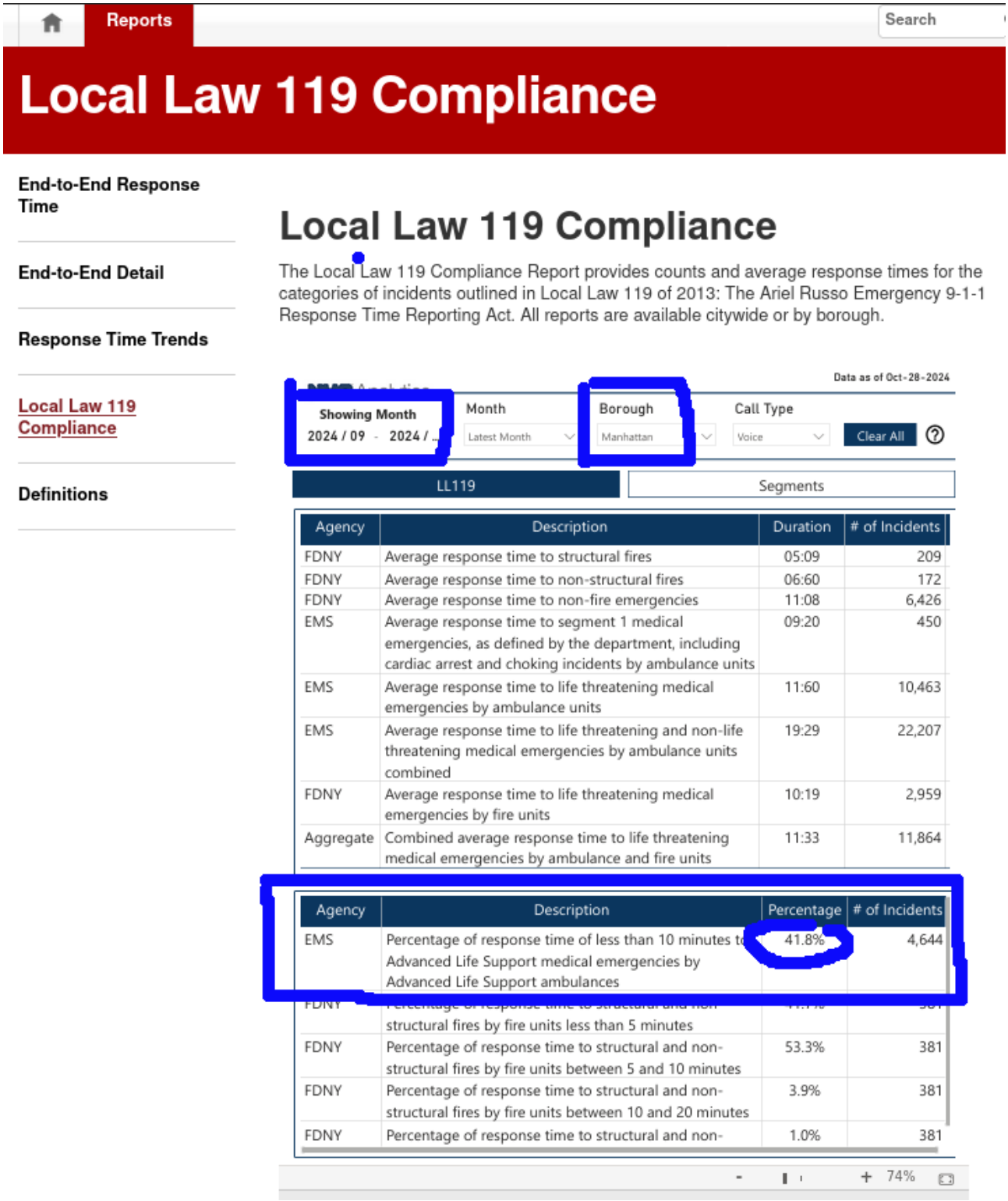
Agency	Description	Duration	# of Incidents
FDNY	Average response time to structural fires	05:36	256
FDNY	Average response time to non-structural fires	07:04	105
FDNY	Average response time to non-fire emergencies	12:34	6,651
EMS	Average response time to segment 1 medical emergencies, as defined by the department, including cardiac arrest and choking incidents by ambulance units	10:30	436
EMS	Average response time to life threatening medical emergencies by ambulance units	13:21	9,902
EMS	Average response time to life threatening and non-life threatening medical emergencies by ambulance units combined	22:31	22,990
FDNY	Average response time to life threatening medical emergencies by fire units	11:22	2,865
Aggregate	Combined average response time to life threatening medical emergencies by ambulance and fire units	12:49	11,516

Agency	Description	Percentage	# of Incidents
EMS	Percentage of response time of less than 10 minutes to Advanced Life Support medical emergencies by Advanced Life Support ambulances	21.8%	3,335
FDNY	Percentage of response time to structural and non-structural fires by fire units less than 5 minutes	30.2%	361
FDNY	Percentage of response time to structural and non-structural fires by fire units between 5 and 10 minutes	65.7%	361
FDNY	Percentage of response time to structural and non-structural fires by fire units between 10 and 20 minutes	3.9%	361
FDNY	Percentage of response time to structural and non-	0.3%	361

74%

9/2024 Data:

Manhattan– Percent of ALS Responses arriving in 10 minutes or less -



Reports

Search

Local Law 119 Compliance

End-to-End Response Time

End-to-End Detail

Response Time Trends

Local Law 119 Compliance

Definitions

Local Law 119 Compliance

The Local Law 119 Compliance Report provides counts and average response times for the categories of incidents outlined in Local Law 119 of 2013: The Ariel Russo Emergency 9-1-1 Response Time Reporting Act. All reports are available citywide or by borough.

Data as of Oct-28-2024

Showing Month 2024 / 09 - 2024 / ...

Month: Latest Month

Borough: Manhattan

Call Type: Voice

Clear All

LL119 | Segments

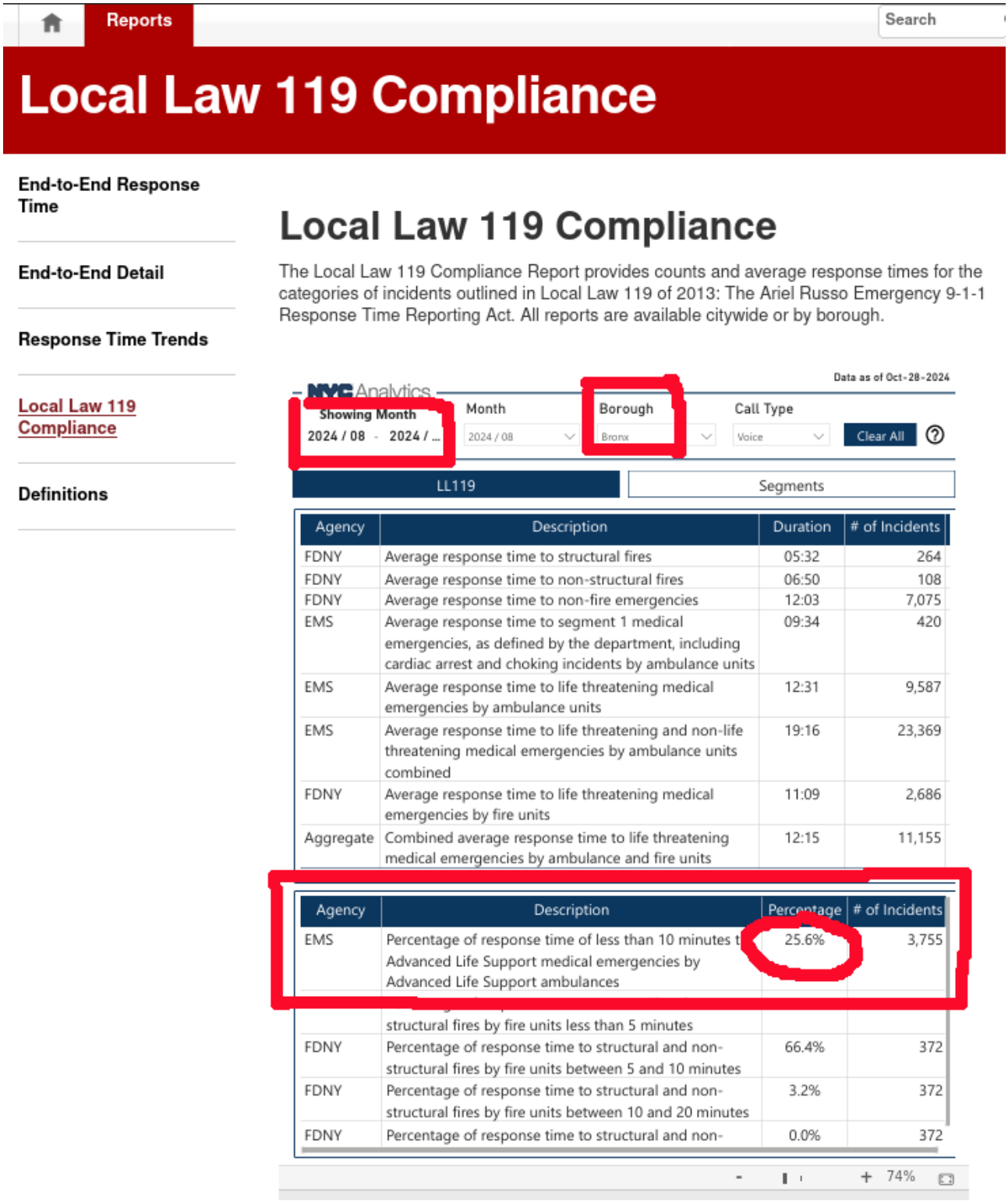
Agency	Description	Duration	# of Incidents
FDNY	Average response time to structural fires	05:09	209
FDNY	Average response time to non-structural fires	06:60	172
FDNY	Average response time to non-fire emergencies	11:08	6,426
EMS	Average response time to segment 1 medical emergencies, as defined by the department, including cardiac arrest and choking incidents by ambulance units	09:20	450
EMS	Average response time to life threatening medical emergencies by ambulance units	11:60	10,463
EMS	Average response time to life threatening and non-life threatening medical emergencies by ambulance units combined	19:29	22,207
FDNY	Average response time to life threatening medical emergencies by fire units	10:19	2,959
Aggregate	Combined average response time to life threatening medical emergencies by ambulance and fire units	11:33	11,864

Agency	Description	Percentage	# of Incidents
EMS	Percentage of response time of less than 10 minutes to Advanced Life Support medical emergencies by Advanced Life Support ambulances	41.8%	4,644
FDNY	structural fires by fire units less than 5 minutes		
FDNY	Percentage of response time to structural and non-structural fires by fire units between 5 and 10 minutes	53.3%	381
FDNY	Percentage of response time to structural and non-structural fires by fire units between 10 and 20 minutes	3.9%	381
FDNY	Percentage of response time to structural and non-	1.0%	381

74%

8/2024 Data:

Bronx – Percent of ALS Responses arriving in 10 minutes or less -



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NYC Analytics

Data as of Oct-28-2024

Showing Month: 2024 / 08 - 2024 / ...

Month: 2024 / 08

Borough: Bronx

Call Type: Voice

Clear All

LL119 | Segments

Agency	Description	Duration	# of Incidents
FDNY	Average response time to structural fires	05:32	264
FDNY	Average response time to non-structural fires	06:50	108
FDNY	Average response time to non-fire emergencies	12:03	7,075
EMS	Average response time to segment 1 medical emergencies, as defined by the department, including cardiac arrest and choking incidents by ambulance units	09:34	420
EMS	Average response time to life threatening medical emergencies by ambulance units	12:31	9,587
EMS	Average response time to life threatening and non-life threatening medical emergencies by ambulance units combined	19:16	23,369
FDNY	Average response time to life threatening medical emergencies by fire units	11:09	2,686
Aggregate	Combined average response time to life threatening medical emergencies by ambulance and fire units	12:15	11,155

Agency	Description	Percentage	# of Incidents
EMS	Percentage of response time of less than 10 minutes t Advanced Life Support medical emergencies by Advanced Life Support ambulances	25.6%	3,755
	structural fires by fire units less than 5 minutes		
FDNY	Percentage of response time to structural and non-structural fires by fire units between 5 and 10 minutes	66.4%	372
FDNY	Percentage of response time to structural and non-structural fires by fire units between 10 and 20 minutes	3.2%	372
FDNY	Percentage of response time to structural and non-	0.0%	372

74%

8/2024 Data:

Manhattan– Percent of ALS Responses arriving in 10 minutes or less -

Reports

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NYC Analytics

Data as of Oct-28-2024

Showing Month: 2024 / 08 - 2024 / ...

Month: 2024 / 08

Borough: Manhattan

Call Type: Voice

Clear All

LL119 | Segments

Agency	Description	Duration	# of Incidents
FDNY	Average response time to structural fires	05:15	190
FDNY	Average response time to non-structural fires	07:08	151
FDNY	Average response time to non-fire emergencies	10:56	6,784
EMS	Average response time to segment 1 medical emergencies, as defined by the department, including cardiac arrest and choking incidents by ambulance units	08:51	431
EMS	Average response time to life threatening medical emergencies by ambulance units	12:02	10,615
EMS	Average response time to life threatening and non-life threatening medical emergencies by ambulance units combined	19:33	22,890
FDNY	Average response time to life threatening medical emergencies by fire units	10:11	3,017
Aggregate	Combined average response time to life threatening medical emergencies by ambulance and fire units	11:41	12,120

Agency	Description	Percentage	# of Incidents
EMS	Percentage of response time of less than 10 minutes to Advanced Life Support medical emergencies by Advanced Life Support ambulances	42.8%	4,699
	structural fires by fire units less than 5 minutes		
FDNY	Percentage of response time to structural and non-structural fires by fire units between 5 and 10 minutes	56.9%	341
FDNY	Percentage of response time to structural and non-structural fires by fire units between 10 and 20 minutes	3.2%	341
FDNY	Percentage of response time to structural and non-	0.6%	341

74%

7/2024 Data:

Bronx – Percent of ALS Responses arriving in 10 minutes or less -

Reports

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NYC Analytics — Data as of Oct-28-2024

Showing Month: 2024 / 07 - 2024 / ...

Month: 2024 / 07 | Borough: Bronx | Call Type: Voice | Clear All

LL119 | Segments

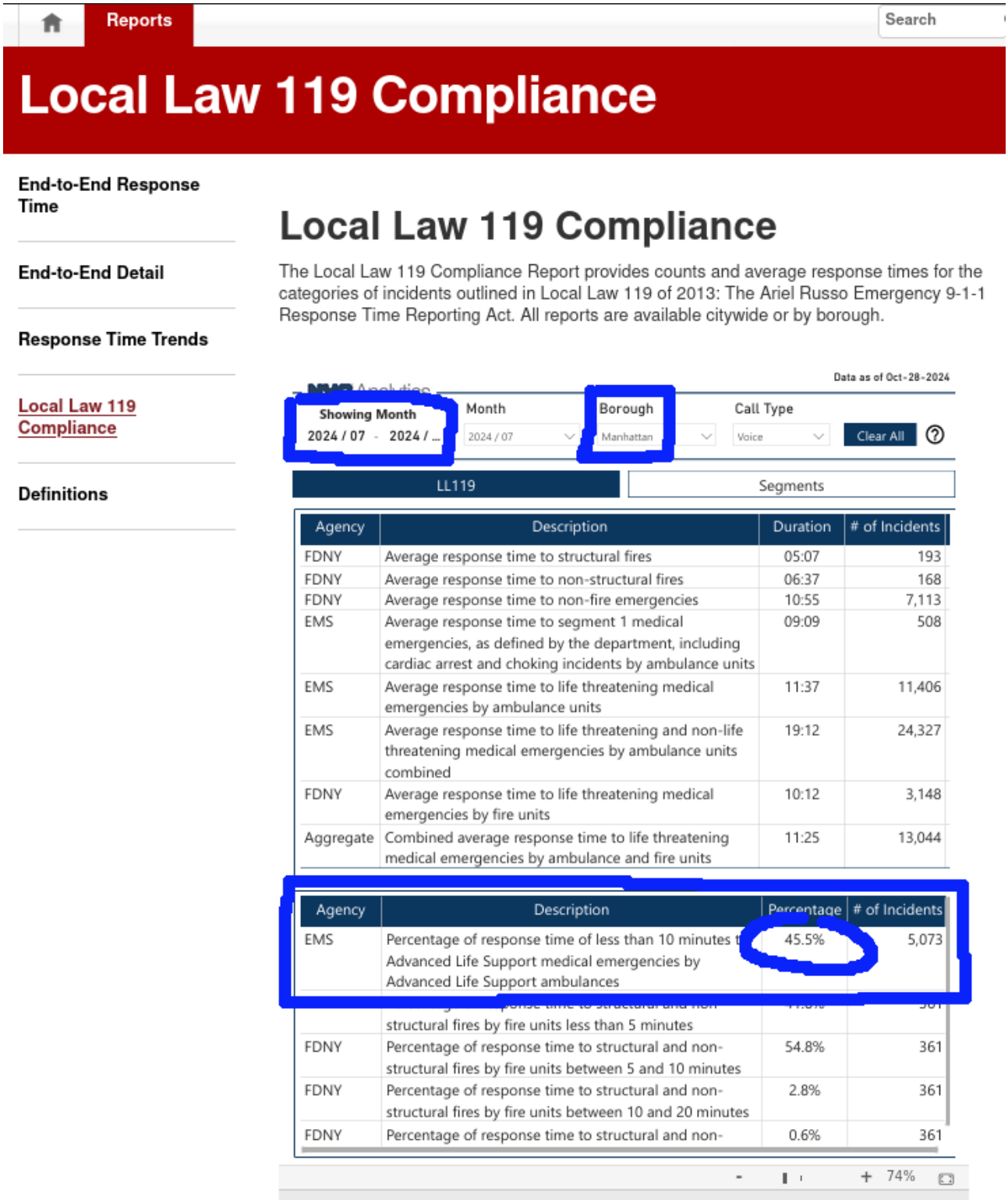
Agency	Description	Duration	# of Incidents
FDNY	Average response time to structural fires	05:38	270
FDNY	Average response time to non-structural fires	07:23	152
FDNY	Average response time to non-fire emergencies	12:28	6,928
EMS	Average response time to segment 1 medical emergencies, as defined by the department, including cardiac arrest and choking incidents by ambulance units	09:49	485
EMS	Average response time to life threatening medical emergencies by ambulance units	13:07	10,459
EMS	Average response time to life threatening and non-life threatening medical emergencies by ambulance units combined	21:45	24,360
FDNY	Average response time to life threatening medical emergencies by fire units	11:27	2,808
Aggregate	Combined average response time to life threatening medical emergencies by ambulance and fire units	12:57	12,043

Agency	Description	Percentage	# of Incidents
EMS	Percentage of response time of less than 10 minutes Advanced Life Support medical emergencies by Advanced Life Support ambulances	25.1%	3,836
	structural fires by fire units less than 5 minutes		
FDNY	Percentage of response time to structural and non-structural fires by fire units between 5 and 10 minutes	65.4%	422
FDNY	Percentage of response time to structural and non-structural fires by fire units between 10 and 20 minutes	3.8%	422
FDNY	Percentage of response time to structural and non-	0.7%	422

74%

7/2024 Data:

Manhattan– Percent of ALS Responses arriving in 10 minutes or less -



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Data as of Oct-28-2024

Showing Month: 2024 / 07 - 2024 / ...

Month: 2024 / 07

Borough: Manhattan

Call Type: Voice

Clear All

LL119 | Segments

Agency	Description	Duration	# of Incidents
FDNY	Average response time to structural fires	05:07	193
FDNY	Average response time to non-structural fires	06:37	168
FDNY	Average response time to non-fire emergencies	10:55	7,113
EMS	Average response time to segment 1 medical emergencies, as defined by the department, including cardiac arrest and choking incidents by ambulance units	09:09	508
EMS	Average response time to life threatening medical emergencies by ambulance units	11:37	11,406
EMS	Average response time to life threatening and non-life threatening medical emergencies by ambulance units combined	19:12	24,327
FDNY	Average response time to life threatening medical emergencies by fire units	10:12	3,148
Aggregate	Combined average response time to life threatening medical emergencies by ambulance and fire units	11:25	13,044

Agency	Description	Percentage	# of Incidents
EMS	Percentage of response time of less than 10 minutes t... Advanced Life Support medical emergencies by Advanced Life Support ambulances	45.5%	5,073
	structural fires by fire units less than 5 minutes		
FDNY	Percentage of response time to structural and non-structural fires by fire units between 5 and 10 minutes	54.8%	361
FDNY	Percentage of response time to structural and non-structural fires by fire units between 10 and 20 minutes	2.8%	361
FDNY	Percentage of response time to structural and non-	0.6%	361

74%

I come from a family of physicians: Father, grandfather, great uncle, twin sister and many first cousins are doctors. Then I married a physician who's father was also one.

Elizabeth Rosenthal, MD is a graduate of Smith College and NYU Medical School. She retired in 2012 from her private dermatology practice in Mamaroneck, NY after 38 years. She is an Executive Board Member of the NY Metro chapter of Physicians for a National Health Program and has been a frequent speaker for that organization. Other activities for PNHP include debates about whether the US or NY State should adopt a single payer system: most recently on Medscape and on a team with Richard Gottfried against a Westchester neurosurgeon and Bill Hammond, the director of health care policy at the Empire Center for Public Policy in Albany. Previously she debated such folks as Sally Pipes, Dr. Avik Roy who was Romney's health care advisor, Dr.Scott Gottlieb who is now head of the FDA and on Fox Business News against a panel of libertarians. She also lead a group of PNHP members to a visit to Toronto where we met with many Canadian physicians and had a splendid program done by Canadian Doctors for Medicare , led by Dr. Danielle Martin of Congressional hearing fame. We were able to sit in with physicians of our specialties and talk to their patients.

Her writing about health care include 10 letters to the editor in the NY Times from 2009 to the present and several op-eds in local papers as well as essays in online journals.

She was an assistant Clinical Professor at the Albert Einstein School of medicine, teaching dermatology residents and medical students in the Pediatric Dermatology clinic from 1974 until Febraury of 2018.

She is also a volunteer for Medicare Rights and the Westchester Library system counseling seniors about Medicare choices. For 30 years she has been on the Board of the Community Counseling Center in Mamaroneck.

She also enjoys lots of outdoor activities as well as reading, knitting, baking and photography. She is married to Sam, also a physician, since 1964 (they met in medical school) and they live in Larchmont, NY and are the parents of three grown sons.

Mount Sinai is attempting to close Beth Israel hospital, and has been permitted to do so by the state, less than five years after the height of the COVID pandemic in NYC. Where are we all going to go if we get sick? I'm a rent stabilized tenant at Stuytown, and I'm really scared. It's not like I, or any of the rent stabilized tenants can easily move. Cabrini hospital and St. Vincent's have already closed, and no new hospitals have opened to fill the gap. And let's be honest: Mount Sinai probably wants to sell the land to a developer who will turn the hospital into overpriced condos - putting even *more* population pressure on the already overtaxed Bellevue. A lot of people don't have health insurance that allows them to go to NYU Langone. I do right now, but a few years ago my insurance would not have covered NYU Langone.

New York City's population is not decreasing! We need hospitals.

PS: I was here during COVID, and I remember that the Javits center had to serve as a makeshift hospital, and the military had to send medical ships in. Hospitals and hospital personnel were overwhelmed. If there is another serious health crisis, this hospital closure would negatively impact not just lower Manhattan, but put pressure on all hospitals in the city.

Best,
Sarah

I am a Pediatric Physiatrist, a specialized physician who treats children with disabilities like spina bífida, cerebral palsy, complex genetic syndromes, premature infants and pediatric concussions. I work in an outpatient clinic at the Child Developmental Center at Morrisania in the Public NYC healthcare system in the Bronx.

We are having issues with recruitment and retention of physicians and not only. It is much more acute than in the private sector due to low wages and decreasing benefits. This creates a great disparity, if not downright institutionalized segregation, in the care of the most vulnerable of New Yorkers. Patients are faced with long waiting times for appointments (I am the only pediatric physiatrist in the system to my knowledge) and patients having to travel from other boroughs or counties to see a specialist.
Closure of hospitals or decreasing the services available at hospitals increases this health crisis and has a devastating impact on the lower socio-economic population due to multiple barriers like language, education, economy and social.
Centralizing care in Manhattan is the wrong way to go. Reducing the initial Primary care visit is the wrong way to go. H+H needs to hire more physicians. It is not equal and equitable healthcare they are giving.

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

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

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: John Roslaven

Address: [redacted]

I represent: Stuy Town Tenants

Address: 470 Madison Ave NY NY

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

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

☐ in favor ☐ in opposition

Date: 10/29/24

(PLEASE PRINT)

Name: Chatodd Floyd

Address: _____

I represent: Greater NY Hospital Association

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

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

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Stephanie H. Theckler

Address: [redacted] NY, NY 10075

I represent: Committee To Protect our Tennox Hill Neighborhood

Address: [redacted] NY NY 10075

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

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

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

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Dr. Laura Iavicoli

Address: Chief Medical Officer

I represent: NYC HHH Elmhurst

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

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

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Dr. Michelle Morse

Address: Interim Health Commissioner

I represent: NYC DOHMH

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. 2118-A

☐ in favor ☑ in opposition

Date: 10/29/2021

(PLEASE PRINT)

Name: Charles NY

Address: _____

I represent: Closing of Hospital

Address: _____

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

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

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

☐ in favor ☐ in opposition

Date: 10-29-24

(PLEASE PRINT) I want to testify

Name: Jean RYAN

Address: 646 77th St. Bklyn NY 11209

I represent: Disabled IN Action of Metropolitan NY

Address: www.disabledINACTION.org

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

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

☐ in favor ☑ in opposition

Date: _____

(PLEASE PRINT)

Name: Blue Rose

Address: 660 WEA NYC 10024

I represent: _____

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

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

☐ in favor ☐ in opposition

Date: 10/29/24

(PLEASE PRINT)

Name: Senator Zellnor Myrie

Address: _____

I represent: _____

Address: _____

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

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

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

☐ in favor ☐ in opposition

Date: 10/29/2024

(PLEASE PRINT)

Name: Charline Oubeni

Address: [redacted] Jamaica, NY 11434

I represent: Supporting Our Mothers Initiative

Address: [redacted] Jamaica, NY 11434

THE COUNCIL
THE CITY OF NEW YORK

28

Appearance Card

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

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Judy Wasser

Address: CPHS

I represent: CPHS

Address: 55 Broad St, NYC

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

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

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Marelie Vilma

Address: (PH)

I represent: (PH)

Address: [redacted] NYC

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

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

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

☒ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: DEBORAH SOCOLAR

Address: [redacted], NY 10027

I represent: self

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

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

☒ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: KAREN FLEMING

Address: [redacted]

I represent: Community Activist

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

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

☒ in favor ☐ in opposition

Date: 10/29/24

(PLEASE PRINT)

Name: Assemblywoman Joanne Simon

Address: [redacted] Bklyn 11238

I represent: _____

Address: _____

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

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

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

☒ in favor ☐ in opposition

Date: 10/29/24

(PLEASE PRINT)

Name: Mark Hannay

Address: 240 E. 4th St. NYC 10009

I represent: Metro New York Health Care for All

Address: Same

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

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

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Harvey Epstein

Address: 122 E 4th Street

I represent: Assembly 74th District

Address: 107 Ave B

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

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

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Mbacke Thiam

Address: [redacted] NYC

I represent: CIDNY

Address: 1010 6th Av 3rd NYC NY 10018

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

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

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

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Redetha Abrahams-Nichols

Address: 450 Clarkson Ave

I represent: Downstate Medical Center

Address: 450 Clarkson Ave

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

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

☐ in favor ☐ in opposition

Date: 10/29/2024

(PLEASE PRINT)

Name: Kimberly Murdaugh

Address: [redacted]

I represent: Save Beth Israel & New York Eye And Ear Campaign

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

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

☒ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Linda Charles

Address: [redacted]

I represent: MSBI

Address: 1st Ave

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

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

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

☒ in favor ☐ in opposition

Date: 10/29/2024

(PLEASE PRINT)

Name: Aixa Torres

Address: [redacted]

I represent: MSDCOP

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

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

☒ in favor ☐ in opposition

Date: 10/29/24

(PLEASE PRINT)

Name: Andrea Gandillo

Address: [redacted]

I represent: Community Board 3

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

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

☐ in favor ☒ in opposition

Date: _____

(PLEASE PRINT)

Name: Renée Kinsella

Address: [redacted]

I represent: myself

Address: _____

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

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

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

☒ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: David Siffert

Address: [redacted]

I represent: Village Independent Democrat

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

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

☒ in favor ☐ in opposition

Date: 10/29

(PLEASE PRINT)

Name: Amelia Wagner

Address: [redacted]

I represent: Community Service Society of NY

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

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

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Katherine Demby (~~Senator Gonzalez~~)

Address: _____

I represent: Senator Kirsten Gonzalez

Address: 801 2nd Ave, Suite 303, NY 10017

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

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

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

☑ in favor ☐ in opposition

Date: 10/29/24

(PLEASE PRINT)

Name: Lois Uttley

Address: [redacted]

I represent: Mayfield

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

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

☑ in favor ☐ in opposition

Date: 10/29/2024

(PLEASE PRINT)

Name: Jesus Perez

Address: 211 East 43rd Street Suite 1404

I represent: Manhattan Community Board 6

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

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

☑ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Mark Ribsin

Address: [redacted] LYC

I represent: 1199 SEIU

Address: 3753 12

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

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

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

☒ in favor ☐ in opposition

Date: 10/29

(PLEASE PRINT)

Name: SUSAN STEINBERG

Address: 5 STUYVESANT OVAL NYC

I represent: STUYVESANT TOWN PETER COOPER VILLAGE TENANTS ASSOC

Address: _____

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

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

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

☒ in favor ☐ in opposition

Date: 10/29/24

(PLEASE PRINT)

Name: SOMMER AMAR

Address: [redacted] NY, NY 10012

I represent: _____

Address: _____

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

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

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

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: ANDREW TITLE

Address: 555 W 57 St NY, NY 10019

I represent: GMVHA

Address: "

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

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

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

☑ in favor ☐ in opposition

Date: 10/29/24

(PLEASE PRINT)

Name: Jose Antonio Gonzalez

Address: [redacted] NY NY 10016

I represent: 1199 SEIU - NSB,

Address: 37th St. 7th Ave

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