CITY COUNCIL
CITY OF NEW YORK

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TRANSCRIPT OF THE MINUTES

Of the

COMMITTEE ON HOSPITALS

Jointly with

COMMITTEE ON HEALTH

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HELD AT: Council Chambers - City Hall

B E F O R E: Lynn C. Schulman
Chairperson

Mercedes Narcisse
Chairperson

COUNCIL MEMBERS: Selvena N. Brooks-Powers
Jennifer Gutiérrez
Kristy Marmorato
Francisco P. Moya
Vickie Paladino
Carlina Rivera
Joann Ariola
Carmen N. De La Rosa
Oswald Feliz
James F. Gennaro
Julie Menin
Kalman Yeger
Susan Zhuang

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

Jumaane Williams
Public Advocate

Michelle Morse
Department of Health and Mental Hygiene
Commissioner

Dr. Laura Lavicoli
New York City Chief Medical Officer

Jessica Gonzalez-Rojas
New York Assembly Member

Zellnor Myrie
New York State Senator

Gustavo Rivera
New York State Senator

Katherine Demby
Behalf of Senator Kristen Gonzalez

Chatodd Floyd
Greater New York Hospital Association

Andrew Title
Greater New York Hospital Association

Joan Rosengreen
New York State Public Employees Federation

Madeline Vilallaba
CPHS

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

Judy Wessler
CPHS

Andrea Gordillo
Manhattan Community Board Three

Jesus Perez
Manhattan Community Board Six

Linda Charles
1199 SEIU

Jose Gonzalez
1199 SEIU

Mark Rubin
1199 SEIU

Amelia Wagner
Community Service Society of New York

Stephanie Heyman Reckler
Committee to Protect Our Lenox Hill Neighborhood

Axia Torres
Alfred E. Smith Houses Resident Association

Renee Kinsella
29th Street Association

Mbacke Thiam
CIDNY

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

Charline Ogbeni
Supporting Our Mothers Initiative

Jean Ryan
Disabled in Action of Metropolitan New York

Deborah Socolar

Mark Hannay
Metro New York Healthcare for All

Lois Uttley

Sommer Omar
Attorney

Kimberly Murdaugh

Bruce Rosen

Dr. Danielle Green
CUNY Graduate School of Public Health & Health Policy

Jeannine Kiely
Democratic District Leader, Save Beth Israel and NYEEI

Mario C. Henry
New York Statewide Senior Action Council

Cynthia Walker
Brooklyn Needs Downstate Coalition

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

Tyler Weaver

Darcy Dreyer
March of Dimes

Christopher Leon Johnson

Tanesha Grant

Benjamin Wetzler

SERGEANT AT ARMS: Good afternoon and welcome to the New York City Council hearing of the Committees on Hospitals jointly with Health. At this time, I need everybody to please silence your cell phones. If you wish to testify, please go up to the Sergeant at Arms desk in the back of the room to fill out a testimony slip. At this time and going forward, no one is to approach the dais. I repeat, no one is to approach the dais. Chairs, we are ready to begin.

CHAIRPERSON NARCISSE: Good afternoon everyone. I am Council Member Mercedes Narcisse, Chair for Hospital Committee. I'm joined by my colleagues Council Member Lynn Schulman, Chair of the Committee on Health. Welcome to today-- and Council Member Carlina Rivera-- where we will be assessing the effects of hospital closure and community needs. New Yorkers are busy folks. This city is made up of parents, caregivers, students, and valued employees who depend on reliable, trusted, and continuous healthcare from the network of hospitals in our communities. People do not necessarily have the time, money or resources to travel long distances for appointments or to go to an urgent clinic care that

does not have records of the complex medical histories. Therefore, it is crucial that they trust the neighborhood hospital to provide the attentive medical assessment and treatment that they deserve. As a registered nurse, I understand the importance of accessibility healthcare on a very personal level. I have seen how vital hospitals are to our communities. I still remember protesting for funding for SUNY Downstate as a young nurse, knowing even then how much Brooklyn depended on this institution. Today, I see the very real risk of closure facing this essential hospital. SUNY Downstate has been a lifeline for our community, not only its Brooklyn's only organ transplant provider and one of the largest maternity hubs, but it has also been a trusted institution that countless residents have relied on for decades, for years. This closure will mean that Brooklyn loses yet another critical healthcare resource, and in my district where we already face the challenge of being a hospital desert. I don't have no hospital in the 46th District. This impact is especially painful for me. Whenever hospital closes, it raises question for the patient in the community. Where will you go if there is an

emergency? As I said, if you have a heart attack, your life become a tick-tock moment where you can lose your life. What will happen to the primary care physician who has cared for you through the years? Like the Public Advocate stated that his doctor is in SUNY Downstate. So, this is personal for most of us here. Will other hospital in your area accept your insurance? As a Registered Nurse, I can personally attest to the heartbreak of seeing a trusted healthcare dissolve, one where my colleagues and I have built lasting relationships with-- patient while providing expert care. When a hospital closes, it opens an entire community network, leaving dedicated staff anxious about their livelihoods, and more importantly, concern about where their patients will find the quality care they need and deserve. As the City Council we must consider the needs of the surrounding communities that will be disrupted by closures, and to ensure that everyone has access to high-quality healthcare. Today, we are gathered to discuss the precautions of hospital closures such as the ones being considered at Mount Sinai Beth Israel and at SUNY Downstate Medical Center. These are storied institutions that have served hundreds of

thousands of patients, employ medical staff and taught student over the years. For me, Downstate, my son graduated from the medical-- he's a medical student that was at Downstate. Now today he's an orthopedic surgeon. For a Black mom in Brooklyn, that mean a lot. We must work together, focus on proactive solution to prevent future closure and safeguard our communities from becoming healthcare desert. It's essential to highlight the specific health needs of the communities affected by these impending closures, as well as the capacity and strain on the neighboring health providers who will have to step in to support residents who have long relied on these facilities. We hope that today's hearing will serve as a productive forum where communities members, hospitals, and policy makers can openly discuss their needs, limitations and plan for the future while thinking of ways to prevent further hospital closures. We thank everyone for joining us and look forward to a meaningful discussion. Before we begin, I'd like to thank committee staff for their hard work in preparing this hearing, Policy Analyst Mahnoor Butt, Legislative Counsel, Rie Ogasawara. I'd also like to thank my staff, Saye

Joseph [sp?], and Frank Shea [sp?] for their work to support me as we work to serve this City Council and our constituents. And now, I would like to recognize my colleagues that's here with us, CM Moya on Zoom, CM Menin, Council Member Yeger, Council Member Marte, Council Member Marmorato, Council Member Ariola, Council Member Paladino, Public Advocate Jumaane Williams, and Council Member Powers. I now will turn it over to my colleague, Chair of Health, Lynn Schulman, for opening remarks.

CHAIRPERSON SCHULMAN: Thank you. Good afternoon. I'm Council Member Lynn Schulman, Chair of the New York City Council Committee on Health. I want to thank all of you for joining us at today's hearing with the Committee on Hospitals chaired by my esteemed colleague, Council Member Mercedes Narcisse. Today, we will be discussing the impact of hospital closures in New York City, an issue that I have been committed to addressing since the start of my first City Council campaign in 2021. The primary focus of this hearing is the impending closure of Mount Sinai Beth Israel in lower Manhattan, the possible closure of SUNY Downstate in Brooklyn, and the impact that such closures would have on the surrounding

communities including access to care and workforce reductions. Hospital closures are not a novel issue. Over the past two decades, the City has lost an alarming number of hospitals. From 2003 to 2014, the number of hospitals dropped by more than 20 percent. Several hospitals in Queens have closed such as Saint Joseph's Hospital in Flushing, New Parkway Hospital in Forest Hills, Mary Immaculate Hospital in Jamaica, St. John's Hospital in Elmhurst, and Peninsula Hospital Center in Far Rockaway. The consequences have been devastating and it is clear that New Yorkers cannot afford to lose locally-available care when it is needed most. It is no surprise that the difference in hospital capacity between the boroughs is drastic. While Manhattan has approximately six hospital beds for every thousand residents, the Bronx, Brooklyn, and Queens each have less than half that number. Queens has the lowest bed to resident ratio of any borough with just 1.4 beds per thousand residents. Organizers have long fought the closure of hospitals in the City, fueled partly in response to the State Medicaid Reduction Taskforce led by Stephen Berger. The Berger Commission proposed cutting healthcare costs by closing "unprofitable hospitals"

or in other words, hospital that serve the most vulnerable New Yorkers. That mentality is unacceptable today, and we will not allow that mentality to be the leading voice for this city or state. That is why I am a co-sponsor of Council Member Rivera's resolution that calls on the State Legislature to pass and the Governor to sign The Local Input and Community Healthcare Act which would require advance notice and engagement with the community before the hospital submits its final closure plan, ensuring transparency and public involvement in the process. I firmly believe that there can be no decisions made for us without us, especially when it comes to our healthcare. This legislation is currently awaiting the Governor's signature, and I hope that Governor Hochul approves this legislation so the public has ample opportunity to consider the impacts of hospital closures on public health, on the healthcare workforce, and on the City's preparedness for future major health crises. I have dedicated my personal and professional life to healthcare advocacy. As someone who has had firsthand experience working in the healthcare field and as a breast cancer survivor, I

believe that these issues must be addressed to ensure that New Yorkers' lives aren't put in jeopardy because of a failing system. Not only are we in desperate need of additional hospital capacity and community-based services, but we need a system that can provide affordable, preventive, and primary care. The COVID-19 pandemic underscored the need for improved local access to quality care within our communities, and we cannot be left with another fatal shortage of hospital capacity when the next pandemic or crisis emerges. No matter what zip code you live in, you should be able to have access to quality affordable healthcare. I want to conclude by thanking Chair Narcisse, my colleagues in the Administration for being here. I also want to thank the Health and Hospital's committee staff as well my own team. I will now turn the mic over to Council Member Rivera to make a statement on her resolution. Oh, and I also want to acknowledge we've been joined by Council Member Zhuang and Council Member Joseph.

COUNCIL MEMBER RIVERA: Thank you so much. I want to-- well, good afternoon everyone. I'm Carlina Rivera. I'm a representative for Manhattan communities and I want to thank Chairs Narcisse and

Schulman for holding this deeply important hearing. I also want to thank my state colleagues who are here from Brooklyn to the Bronx who have shown up in support because they know how critical our hospitals are to each and every one of our communities. I'm very, very proud to be working in coalition with local advocates and elected colleagues to protect access to high-quality healthcare as Mount Sinai moves forward with closing Beth Israel in our community. Without details, this decision leaves the health and wellbeing of 400,000 Manhattan residents in question, and our community has already seen services move uptown and west, and at this time Manhattan residents below 14th Street have less than one hospital bed per 1,000 people. Local emergency room wait time are already very high, and Beth Israel sees 70,000 emergency room visits a year, but this goes beyond an emergency room. Beth Israel is a full-service hospital that has slowly been moving core hospital services such as maternity care and childbirth to other locations within their network, all located uptown above 57th Street. Women need access to quality care as we face a maternal health crisis in our city and people deserve access to a

full suite of services that help maintain good health and wellbeing. Hospital closures harm our most vulnerable communities and reduce our readiness for emergency events. Remaining hospitals and health centers will be overburdened and will face the same financial challenges, but with fewer resources. We must enhance community engagement requirements for proposed closures, improve regional planning efforts and take every step necessary to safeguard healthcare access for all. I'm very thankful to my colleagues at the state level for the Local Input in Community Healthcare Act and I urge the Governor to sign it, and for of course, the State to put additional resources into assessing how we can adequately and equitably serve our communities and ensure healthcare for all. Thank you.

CHAIRPERSON NARCISSE: Thank you. Now, we're going to hear from Public Advocate Jumaane Williams to make his statement.

PUBLIC ADVOCATE WILLIAMS: Thank you, Madam Chair. As mentioned, my name is Jumaane Williams, Public Advocate for the City of New York. I'd like to thank Chair Schulman and Narcisse and the members of 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 U.S., we saw hospitals on the verge of collapse, our medical staff overworked and overwhelmed, and 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 systems remain 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 more color. We have often bared 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 1st Avenue in Manhattan, and SUNY Downstate Medical Center in Brooklyn. In losing these hospitals we are losing access to beds and precious resources, and we really can't afford to go back, and I'm aware in the past 25 years, the way we present medical care has changed, but the need for it has not. So my hope is that we can work with the communities on how best to

present it and not close down these institutions. And of course, it puts a strain on Health + Hospitals, our safety-net hospitals. Recently, doctors at Health + Hospitals were instructed to cut patient visits from 40 minutes to 20 minutes, a measurement to all more patients to be seen as the demand for care grows. Since 2021, H+H systems have added roughly 60,000 unique patients to their care, leading to longer wait time for an appointment but limiting the time per patient visits run the risk of diminishing quality of patient care and further contributing to burnout amongst physicians and other medical professionals. When it comes to migrant populations, it is important to remember that many patients require translation services, lengthening duration of visit. 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 till affect many New Yorkers today, and we have put no long-term resources into addressing that reality. Not only was this decision made without the consultation of doctors and the representation of Doctor’s Council

SEIU, but these decisions further fail to address the lack of attention and recruitment contributing to burnout and high rates of turnaround. After a year of contract negotiations with Health + Hospitals affiliates, Physician Affiliate Group of New York, Mount Sinai, New York Langone, the Doctor's Council is no closer to a contract and addressing the concerns of its members. As a city, we simply cannot allow our public health system to collapse. Right now, our system is stressed. In the case of SUNY Downstate, many inpatient services were moved to Health + Hospitals Kings County Hospital which is already stretched thin. According to Redetha Abrahams-Nichols, President of the Downstate Chapter of United University Professionals, this spring saw the emergency room of Kings County packed with 80 patients sitting without beds on the floor with wait times over 12 hours. Similarly, in the case of Beth Israel, the hospital closest by NYU Langone Health and the city-run Bellevue will be impacted. This follows the closure of two large nearby hospitals in the past 20 years, Cabrini and Gramercy [sic] Park, and St. Vincent's in Greenwich Village. City and State elected officials must come together to address

these issues and ensure our public health system if fully-staffed and fully-funded with dignity and care ensured for patients and healthcare workers alike. And as Chair Narcisse mentioned, this is personal to me as well. I received life-saving care when I was younger at SUNY Downstate. My sister is a Nurse Practitioner from SUNY Downstate, and my Primary Care Physician is from SUNY Downstate. Not sure what happens if SUNY Downstate closes. Thank you so much. Appreciate it.

CHAIRPERSON NARCISSE: Thank you. Now, we will be hearing testimony from the representative from the Administration. I now turn to Committee Counsel to administer the oath for this panel of the Administration.

COMMITTEE COUNSEL: Good afternoon. We will now hear testimony from the Administration. Before we begin, I will administer the affirmation. Panelists, please raise your right hand. I will read the affirmation once and then call o each of you individually to respond. Do you affirm to tell the truth, the whole truth and nothing but the truth before this committee and to respond honestly to Council Member questions?

COMMISSIONER MORSE: Yes.

CHIEF MEDICAL OFFICER LAVICOLI: Yes.

COMMITTEE COUNSEL: Thank you.

COUNCIL MEMBER NARCISSE: Now you may begin.

COMMISSIONER MORSE: Can you hear me? Good morning Chair Schulman, Chair Narcisse, and members of the Committee on Hospitals and the Committee on Health. I am Doctor Michelle Morse, Interim Health Commissioner at the New York City Health Department and Chief Medical Officer. I'm joined here today by my colleague, Doctor Laura Lavicoli, Chief Medical Officer of New York City Health + Hospitals Elmhurst. Thank you 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 aware, hospitals are 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, healthcare workers, public health, socio-economic stability and the overall health care system, especially hospitals located in marginalized communities. But before we address solutions, we have to identify the problems. Today, I will outline the business of healthcare 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 healthcare which includes hospitals. Under New York State law, that authority lies with the New York State Health Department. However, the New York City Health Department does have a critical role in using data, narrative-change, community engagement, and technical assistance and ensure a more accountable and equitable healthcare 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 healthcare system during last year's hearing on healthcare 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 healthcare system; rather, these 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 healthcare 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 communities. Racial segregation in healthcare is in part maintained by reimbursement systems that directly incentivize healthcare providers to deliver care to those who can pay more. Our healthcare 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 health 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 healthcare needs are more likely to be sidelined. Teams at the New York City Health Department are implementing City Council's recent healthcare 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 healthcare 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. Our aim is to work alongside hospitals and healthcare systems to identify business practices and behaviors that have led to systemic inequities, including segregated care, and to address harms. More can be done to equip hospitals and healthcare systems with the tools

they need to hold themselves accountable by taking measurable, objective steps to combat structural racism and promote health equity. One useful example comes from Illinois where healthcare 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 and other health inequities. This is a valuable tool that highlights the importance of examining all aspects of an organization, not only 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. 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 my colleague, the New York State Health Commissioner, Dr. Jim MacDonald. 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 healthcare for all individuals, contribute to public health, support the economy, and help build a more equitable healthcare system. Their role is fundamental in promoting the health and well-being of communities, particularly those that are in most need. Secondly, safety net hospitals are often under-resourced at baseline because of how the healthcare payment system is built. Most notably, some services, such as specialty care, are reimbursed at higher rates than other services, and commercial or private insurance also reimburses at higher rates than public insurance programs like Medicaid and Medicare. In addition, essential services such as maternal and neonatal, mental health, and injury services are disproportionately provided by safety-net hospitals. However, these essential services are

less profitable, placing financial strain on safety-net hospitals that disproportionately provide them. 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 or under-compensated care, many safety-net institutions also provide services to address social needs such as food and housing assistance which also 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. That study highlights New York State's 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 closures are part of a vicious cycle. Demand by the healthcare industry for maximum profits in all areas of healthcare and a lack of accountability when large public subsidies are given in the form of tax exemptions to nonprofit hospitals can pose threats to safety-net hospital 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 healthcare transparency, accountability, and equity. Thank you for the opportunity to testify and I am happy to answer any questions.

COUNCIL MEMBER NARCISSE: Thank you. I forgot to mention in the Chamber, if you agree, you want to let it be known-- thank you. You may begin. You have testimony? Oh, alright. Alright, so you guys going to answer questions. Alright. First I have to say I'm very, very happy that you're able to make it here with us, and my quest-- Over the past two years, what are the most notable health trends requiring inpatient services that you have observed, are the hospitals, clinics and other medical service providers located in lower Manhattan and downtown

Brooklyn are [inaudible] equipped to address those health trends if Beth Israel and SUNY Downstate are closed?

COMMISSIONER MORSE: I'll get started and then I'll pass to Doctor Lavicoli. The first thing that I would say is that the State Health Department does really monitor that data most closely. The Health Department does issue community health profiles for every community district across the City that are updated regularly, and those are publicly available, and the Health Department does track trends in needs for healthcare using those community health profiles and State Health Department data. Over the past couple of years we know for sure, of course, that respiratory viral season has been an intense and challenging time every winter, every fall and winter across the City, and I would encourage everyone who's listening today to get their updated COVID vaccination and flu shot and RSV shot if you're eligible. And you can find out where to get those on the New York City Health Department Vaccine Finder website. I would also say that in addition to respiratory viral season being very, very busy over the past couple years, several years since the

pandemic started, we certainly also are looking closely at trends in chronic disease and chronic disease-related hospitalizations. Those are two of the most common reasons for hospitalization across New York City. However, again, it's the State Health Department that really looks at that data more closely and more regularly than we do. I'll pass to Doctor Lavicoli to share more.

CHIEF MEDICAL OFFICER LAVICOLI: can you hear me? Okay. So, New York City Health + Hospitals is the safety-net system of, you know, New York City, and we are committed to serving all New Yorkers no matter race, ethnicity, gender, ability to pay, insurance, uninsured status, and that is our commitment. So, no matter what the fallout from a hospital closing, we are here to serve. We have done it before. We have stood up. We have met the challenge in COVID, and that is what we're here to do.

CHAIRPERSON NARCISSE: I know during the height of the pandemic, Downstate stepped up big time, and if Downstate were not-- I mean, was not there, I cannot just imagine. So I'm going to continue my questioning. I'm just picturing those

things in my mind. I'm just hopeful as a nurse that we're not going to go no time soon we'll be experiencing pandemic or epidemic in the City, because closure of the hospital is very alarming to all of us that in medical field, and I'm sure with you, too. I've been joined by my colleagues Council Member Feliz, De La Rosa, and I will say Selvena Brooks-Powers. This is our majority Whip, so that's [inaudible]. What are the most common reasons for an emergency department visit in Manhattan right now?

COMMISSIONER MORSE: so, the State Health Department does publish some of this data. The Health Department, the New York City Health Department partners with and shares data with the State Health Department. We can get back to you with more information about the most common causes in Manhattan.

CHAIRPERSON NARCISSE: When we do ask the question, I know some of them is the state driven data collecting, but at the same time, I know that Department of Health for our City have to be well in tune with the numbers and making sure that we're well taken care of. I have faith that we'll be well taken care of. We've been well taken care of, but you know

what I'm talking about, right? Okay. The hospital closure process in New York is wholly governed by the New York State Department of Health. Is Department of Health here included or consulted at any point in the course of the State Department of Health decision-making process when they are evaluating whether or not to approve a hospital closure?

COMMISSIONER MORSE: So, the State Health Department does have the regulatory jurisdiction around hospital closures. We do communicate with them and meet with them regularly and do coordinate across New York City and New York State around public health priorities. However the decision about hospital closures is fully within the realm of the New York State Health Department. It is not in our jurisdiction in the New York City Health Department. The ways that we would share information include, of course, a sharing information like the community health profiles I mentioned, the potential impact that we think could happen in New York City. However, it is fully the State Health Department's decision. The final thing I'll mention is that there is a process that the state conducts called a certificate of need process. That process is used

for opening additional beds or services and closing additional beds, some beds and services. Although there is not a specific bill that has passed that requires community consultation around hospital closures, there is a process called the health equity impact assessment, and the New York City Health Department does sometimes get asked to weigh in about the impact, the health equity impact of hospital services being added or changed. We do not, however, have-- there is no requirement for there to be a health equity impact assessment when there is a hospital closure. That is not part of the process.

CHAIRPERSON NARCISSE: This is-- there is a health equity impact right now, because we're talking about a closure of a hospital which is the state hospital right across the street from city hospital more likely, right? So, if the conversation has been that county which is the city hospital, right, going to be taking over those folks, right? You in the early phase-- let me step back. When you're aware, when does Department of Health aware that Downstate was about to close? Is that a beginning or when it became public?

COMMISSIONER MORSE: The New York City Health Department is not consulted in the plans or decisions around hospital closures. It really is a State Health Department decision. So we became aware of the potential closure when it became public, and then just to clarify, there is this certificate of need process that is overseen by PHHPC committee in the New York State Health Department, and that process does ask for a health equity impact assessment for changes in hospital services, additions, or closures. It-- however, the health equity impact assessment process does not apply to hospital closures. And again, that process is run by the State Health Department. Sometimes the New York City Health Department is asked to weigh in on a health equity impact assessment, but again, that is not-- those are not used for hospital closures.

CHAIRPERSON NARCISSE: This is a tough one for me. We're learning. How long are the wait times for most visitors of an ED in Manhattan hospitals? I'm just trying to understand something here.

COMMISSIONER MORSE: I can start and then I'll pass it to Doctor Lavicoli.

CHAIRPERSON NARCISSE: Because I'm still-- because there's no impact. I mean, we don't have to know about when the state is closing. We don't have to know, but then again, there is a correlation directly. So I'm lost on that one. That's what I'm-- okay. Let me move on, because I'm-- you have something you can contribute to me, Doctor?

CHIEF MEDICAL OFFICER LAVICOLI: So, I mean, what I can say generally about wait times in emergency Departments is that-- and just as an emergency medicine physician. We see patients emergent, urgent and non-urgent. So, we will see patients based on their acuity no matter what the volumes are, and we're used to scaling up. We are used to scaling up based on season, based on volume, based on time of day. This is what we do. We've done it before. We can scale up for, you know, any event. So we will be ready no matter what.

CHAIRPERSON NARCISSE: Okay. I guess I'm going to move on, because I'm still lost a little bit, and bear with me, because I'm just trying to understand. Because like, for instance in Manhattan, the beds per patient, right? For example, in Manhattan is about-- the statistic is about 5.34 or

36, right? But in the meanwhile in Beth Israel the area where potentially they're going to close the hospital is 0.81. So-- per thousand. So there is something I'm trying to understand, but I'm going to come back to that. Over the last year, have you seen any increase in the number of patients visiting Bellevue Hospital and Kings County Hospital? If so, what is the percentage increase from the last year? Can this increase in patients be attributed to Beth Israel or SUNY Downstate in the process of closing?

COMMISSIONER MORSE: I'll pass that to my colleague, Doctor Lavicoli.

CHAIRPERSON NARCISSE: Alright.

CHIEF MEDICAL OFFICER LAVICOLI: I mean, the one thing that we just know publicly is that emergency department visits across the city are up 6.5, I think, percent is what has been said in, you know, publicly and data in the media. We are all very busy. We are all working very hard. We are all very strained. Specifics to these two hospitals, though, I cannot answer. But it is across the City volumes are up.

CHAIRPERSON NARCISSE: Okay. For either one of you, in the past have you had experience with

running standalone emergency department, and have they been effective in meeting community needs? If not, what were the biggest challenges that medical staff and patients face?

COMMISSIONER MORSE: the New York City Health Department does not run any standalone emergency departments. I can pass to Doctor Lavicoli.

CHIEF MEDICAL OFFICER LAVICOLI: New York City Health + Hospitals also doesn't run standalone hospitals or emergency departments. The only thing that I can say generally is that there is-- they don't have specialty care in them, and not as geared towards the highest acuity. So, patient transfer is what is usually set up in those types of facilities. But again, we don't have them in New York City Health + Hospitals.

CHAIRPERSON NARCISSE: When St. Vincent Hospital close in the West Village close in 2010, what were the most acute impacts on the neighborhood hospitals and the patient in the community? Do you recall any increase in wait times for emergency care for the hospitals in lower [sic] of western Manhattan that resulted from the closing?

COMMISSIONER MORSE: Thank you for asking a question about recent history. From what we know, of course, any time there is a hospital closure there are ripple effects on the community that that hospital serves. It-- we don't need research studies necessarily to tell us that hospital closes, the community that used that hospital will have to seek care in other places, either in that specific community if there are other hospitals available or elsewhere. So, our general sense, of course, is that if a hospital closes, the impact on the community that it serves will be that those community members will need to seek care elsewhere, and they also will lose the relationship that they have with the providers of the hospital that closed. In general, we would of course just assume that the surrounding hospitals would have more patients to see if a hospital closes, because the people seeking care in that community would need to seek care elsewhere in that local community. And I'll pass to Doctor Lavicoli in case she would like to add.

CHIEF MEDICAL OFFICER LAVICOLI: I mean, I would just echo the same thing as Doctor Morse said. I mean it is, you know-- in a densely urban

center is a healthcare ecosystem and there will be effects is one of the hospitals closes in that ecosystem on the surrounding hospitals in that area.

CHAIRPERSON NARCISSE: I know that Kings County, right, is overwhelmed right now as we speak. So now, having Downstate to be closed where is all those patients going to go? The hospital, I believe, in maternal health, the Kings-- I mean, Downstate delivery is about 600 something, somewhere I read earlier, and the county is about 700 something. So where those babies going to be delivered, so for those folks in those communities. I'm just thinking one example.

COMMISSIONER MORSE: As a clinician who practices at Kings County Hospital and spends time in the emergency room there, it is one of the busiest emergency rooms in the state. That is what the state health data tells us, and that data is publicly available, and I would also say that although we can't predict exactly what the impact would be on Kings County Hospital, were SUNY Downstate to close, as I mentioned, we don't need a study to tell us that the ripple effects would be that people seeking care

in a hospital that closed will have seek care elsewhere.

CHAIRPERSON NARCISSE: Somewhere else.

COMMISSIONER MORSE: The State Health Department is responsible for doing the planning in partnership with any hospital that closes around where the community that uses that hospital should seek care, and is responsible for also doing planning to mitigate any impacts on the hospital that uses that hospital-- on the community that uses that hospital.

CHAIRPERSON NARCISSE: So, when they're making the plan, the state make the plan, right? But we live in New York City. Department of Health, I'm assuming, and H+H were wondering what's going to happen and they need that-- those data early so they can plan accordingly, because we're talking about human life.

COMMISSIONER MORSE: I think we agree with you that the access to healthcare is a right. We, in the New York City Health Department, also believe that everyone should have access regardless of where they're born, where they live, their race, ethnicity or anything else. So were 100 percent agree

that everyone should have to care, but it really is up to the state to plan with the institution that is under consideration for closure to mitigate any harms or impacts to the community that uses that hospital.

CHAIRPERSON NARCISSE: What can New York state and the City Council do to support hospital in the City and prevent further closure?

COMMISSIONER MORSE: thank you for that question. I think we in the New York City Health Department are grateful that Council is prioritizing this issue and holding the hearing today. We think it is really important for us to be able to have open dialogue around this kind of issue that impacts health equity and access to care in communities across New York City. we also in the New York City Health Department really do see our role as assessing data across the City, partnering with the State Health Department where we can, and then one of the things that is helpful from Council is you all hear from your constituents about their concerns and the potential impacts of healthcare access and hospital closure on their lives, and as you hear those things and those concerns, sharing them with us at the Health Department also allows us to plan and also

allows us to mitigate as much as we're able to. But again, in this particular case, it's the State Health Department that is the decision-maker. And sorry, finally, one other area where City Council of course has significant impact is coordinating with and being in conversation with State Assembly and Senate colleagues who themselves are also really responsible for, in partnership with the State Health Department, addressing issues of health equity and hospital closures. And I'll pass it to Doctor Lavicoli in case she'd like to add to that.

CHIEF MEDICAL OFFICER LAVICOLI: So, the only thing I would add is that, again, I'll just reiterate what I had said that we're here to serve our community, our patients. We will continue to assess what the City and H+H leadership around what the impacts will be, and we'll scale-up as necessary.

CHAIRPERSON NARCISSE: You know, being a Registered Nurse for over three decades, it's kind of tough for me, because I'm sitting here. I lived some of the experience in the hospital in the ER, by the way, in the public hospital H+H. Knowing that I did internship in Kings County, even back in the day it was very chaotic. It's a lot. It's busy like God

knows, and that's where most folks-- actually, I'm thankful for H+H because those are where people with no insurance-- and that's another conversation. Medicaid increasing should be. So I'm very grateful for that, but I know how busy the hospital is, and then now for closing a hospital directly going to impact the people where I live, where I, you know, move with, and even the Public Advocate's doctor is in there. So when you live in Brooklyn-- and I'm sure the Council Member, Chair for Education, mentioned earlier, too, that she has experience, because this is directly impacting us as people, and that's the reason I'm kind of trying to get the full understanding to see where we can fit to make sure that we address health inequities for real in our community. So, if I come across asking too many questions, trying to-- because we have to do better, because we are New York City. And I do understand that health sometimes is not sexy when you're not sick and we saw what happened with the pandemic, so we got to do better. We got to do better. We cannot keep on closing hospital. Can you describe how the pandemic impacted hospital's financial performance

prior to 2020, and what was the fiscal landscape and how it has changed?

COMMISSIONER MORSE: I'm not privy to the individual hospital financial data or inner workings. However, we know that every hospital during the pandemic experience, of course, a surge in inpatients and ICU patients, and we also know, of course, that the emergency rooms were significantly impacted. We did in the New York City Health Department do an analysis looking at hospitals across the City and what changed for them in the months following the first wave of the COVID pandemic, and in that study which was published and freely available online, we were able to show that hospitals that had a higher proportion of patients that were uninsured or underinsured, those hospitals had challenges with a large volume of patients, and that impacted patient morbidity and mortality during the first week of the COVID pandemic. For the financial data specifically, I do not have that information for each hospital today, but I'll pass to Doctor Lavicoli in case she'd like to comment for Health + Hospitals.

CHIEF MEDICAL OFFICER LAVICOLI: I don't have anything further to add, but we can certainly get you that information. I don't have it firsthand.

CHAIRPERSON NARCISSE: Has the delivery of healthcare changing and what impact does it have on the current hospital system and the provision of services?

COMMISSIONER MORSE: I think we both, Doctor Lavicoli and I, as clinicians have seen lots of changes in healthcare, and certainly at the Health Department we've also seen these changes. Telehealth is obviously rising and is much more common and commonly accessible now than it was prior to the pandemic in New York City, so that is one change that is noteworthy and significant, and I would say that there are a number of other changes, of course, in terms of volume of patients as Doctor Lavicoli mentioned. Volume in emergency departments is up, and I think-- I'm not sure if there are any other specific trends that are worth mentioning at the moment, but healthcare is constantly changing and the needs of the communities we see and care for across New York City are also constantly changing. I'll pass it to Doctor Lavicoli in case she'd like to add.

CHAIRPERSON NARCISSE: Thank you.

CHIEF MEDICAL OFFICER LAVICOLI: I agree with the telehealth, and New York City Health + Hospitals does have 24/7 virtual express care which is 24/7 telemedicine for non-urgent medical problems in 200 different languages including sign language and it is a service that is, you know, invaluable to anybody and its accessible to anybody and very affordable. Some of the other things I could just say would be data-driven decision-making that, you know, more and more we're relying on data to guide us in healthcare.

CHAIRPERSON NARCISSE: And I have to tell you, honestly, I love telehealth, telemedicine, because a lot folks can, you know, have access especially the homebound. I used to do home care, too, by the way, and when you do home care you know how the patient that's homebound how difficult it is for them to get out to go [inaudible] their appointments. And but we still have to work and improve in terms of making technology accessible throughout New York City and find out the homebound folks that we can give great access for them as well, and I hope you can help me push that, because I want

to push that more, because there's a lot folks that still home and they're still complaining about how the transportation Is not good and they still cannot get to the doctor's and they don't have the access to technology. Alright, thank you. And what can New York State and the City Council do to help strengthen the hospital workforce?

COMMISSIONER MORSE: Well, I would say that the workforce, the health workforce in particular, is one of the most important areas of work. we are aware, of course, that the New York State Health Department is investing in the workforce through the 1115 waiver that was recently approved, and it in general is mostly up to the AAMC and to other accrediting bodies to really ensure that there's an adequate pipeline of health workers that are trained to meet the needs of the nation. In New York City specially, that often falls to academic medical centers as well as, again, support from the state around training and support from the federal government around training.

CHIEF MEDICAL OFFICER LAVICOLI: I would just add that New York City Health + Hospitals really is committed to building its workforce with the best

talent that represents its communities and has incredible initiatives including Docs for New York City, a physician recruitment campaign for a primary care physicians, Nurses for NYC which is a nurse recruitment for New Yorkers to apply for a nursing positions at Health + Hospitals, Psych Docs for NYC for psychiatric positions, Mosaic which is a Medical Opportunities for Students and Aspiring Inclusive Clinicians. This is an initiative to help students and trainees of under-represented backgrounds gain clinical and experiential opportunities at Health + Hospitals. Nurse Fellowship Program, Nurse Residency Program, and the BH4NYC program which help to support loan repayment for our behavioral health workforce.

CHAIRPERSON NARCISSE: I do appreciate the nurse's residences program, because I think it's an awesome program. So, I spoke to Doctor Katz about it, I'm so pleased to have that program to create opportunity. So, for H+H-- other than expanding services at Bellevue, are there any other anticipated course that Health + Hospitals or Gotham Health Centers would expect from the closure of Beth Israel? Cn you answer that one?

CHIEF MEDICAL OFFICER LAVICOLI: We are still assessing should the hospital close what the impacts will be and just reiterating whatever they are, we know how to scale up and we will be able to accommodate any increase in volumes.

CHAIRPERSON NARCISSE: For SUNY Downstate, while we understand that the next step of SUNY Downstate's future will not be decided until next April at the earliest, in the event that Downstate reduces services, what kind of changes to Kings County Hospital facilities or staffing will need to be implemented to keep up with the patient needs in Downstate Brooklyn-- for the Downstate Brooklyn community?

CHIEF MEDICAL OFFICER LAVICOLI: I mean, it's a similar answer. So, should SUNY Downstate close, Health + Hospitals is working with the City to fully understand the impacts and we'll be ready to accommodate the impacts and any changes to the volumes.

CHAIRPERSON NARCISSE: Are you steady before it happened? Or are you waiting for it to close? What phase we are in?

CHIEF MEDICAL OFFICER LAVICOLI: I mean, Health + Hospitals is currently working with the City to understand what the impacts would be and make sure that we're ready.

CHAIRPERSON NARCISSE: Sunny Downstate runs the only kidney transplant program in the entire borough of Brooklyn. If they were to close, would Kings County be able to absorb patients in need of kidney transplantation or would patients need to go to a private hospital or to a facility in another borough?

COMMISSIONER MORSE: I will answer first, and then I will pass it to Doctor Morse, but Health + Hospitals does not have a kidney transplant program.

CHAIRPERSON NARCISSE: I know that and that's worried me a lot. That's one of the reasons that I was there about 15, 16 years ago to prevent that from happening for us to come. And unfortunately, the investment in our hospitals is a problem, and especially those that rely on Medicaid and Medicaid is not moving. So, you have something to say, I think to add to it?

CHIEF MEDICAL OFFICER LAVICOLI: I'll just add to your comments and to Doctor Lavicoli's

that, you know, this is certainly a serious health equity issue. Access to kidney transplant is a major challenge in the city at baseline. The wait lists are quite long. It is also a racial equity issue. There is a large inequity in the number of people who are Black who get access to kidney transplants, and as far as we are aware the SUNY Downstate kidney transplant program has transplanted over 3,000 people in the Brooklyn area since it was established. So we do consider access to specialty care like kidney transplant to be a critical health equity issue for Brooklyn.

CHAIRPERSON NARCISSE: You know that's one of my things, fighting for equity when it comes to transplants, and now to close Downstate, that means I'm stepping a few step back and step backward. Has health science-- I mean as a health science university Downstate is involved in providing education and training for students in the college of medicine, which is like my son, College of Nursing, School of Graduate Studies, School of Health Professions, and School of Public Health. How would the potential changes to Downstate impact those students?

COMMISSIONER MORSE: I can just start by saying of course it is the state's responsibility.

CHAIRPERSON NARCISSE: I know.

COMMISSIONER MORSE: SUNY is a state school and so it is the state's responsibility around training. They're the decision-maker on this, and what we also know, of course, is that the next generation of health workers have to be trained in high-quality settings, medical schools, nursing schools, etcetera. So, certainly, I think the state, you know, again, will be responsible for figuring out what the impacts would be and where alternative training sites would need to be if they were to decide to close the SUNY Downstate inpatient beds.

CHAIRPERSON NARCISSE: You know I'm very concerned. Every time you repeat it. I know that's what it is, but then again, it is unfortunate that the state responsible, but we live in the City of New York, and we need to defend. That's why I'm so happy for the next panel, and I'm hoping that you can stay, because that's the state folks that coming up, because we have to find a way to make sure that health-- we have to deliver quality of health in New York City. That's our responsibility. Even through

the state, but the state we have to collaborate together to get this thing done. Alright, so I'm going to pass it on, and I can always come back if I have more questions, but I'm going to turn it to my colleague, Chair Schulman.

CHAIRPERSON SCHULMAN: So, I'm just going to go a little out of order here before I ask you questions. I have Assemblywoman Jessica Gonzalez-Rojas who's on the Health Committee of the Assembly and also from Queens. She has to leave. She has an engagement. She'd like to just make a very brief statement. Assemblywoman Rojas-Gonzalez are you on?

ASSEMBLY MEMBER GONZALEZ-ROJAS: Yes, thank you so much for having me, and I'm sorry to interrupt, but I want to thank Chairperson Schulman, Chairperson Narcisse and the members of the Council's Committee on Health and Hospitals. My name is Assembly Member Jessica Gonzalez-Rojas. I proudly represent the 34th Assembly District in Queens, and I testify today as a member of the Assembly's Committee on Health and as a public health activist and advocate. My testimony today can be summed up in a simple question and one that I've been asking myself for quite some time. Why does the borough of Queens,

the largest borough, the second-most populated borough in our city have only 1.65 hospital beds for every thousand people, while Manhattan has 5.7 hospital beds for every thousand people? And obviously, I don't want to start tensions between the borough, but I'm deeply concerned that we have not learned our lessons from the COVID-19 pandemic. As many of you know, Corona Queens which I represent was the epicenter of the epicenter, and while Elmhurst Hospital serves my constituents and the larger community it's not enough. Our safety-net hospitals need more support and we're urgently fighting for that, but we also need to build more capacity equitably across our city. According to the New York Health Foundation, since 2000 40 hospitals have closed in our state, including more than a dozen in the City which accounted for a loss of nearly 21,000 hospital beds statewide during that time, and this downward trend is dangerous and leaves our most vulnerable New Yorkers in a very precarious situation. Accumulative impact on our healthcare system is also difficult. The closure of any one hospital impacts the capacity of our neighboring hospitals. In 2012, City Limits reported that after

Mary Immaculate and St. John's Hospitals in Queens closed their doors in 2009, Elmhurst Hospital saw a staggering uptick in patients. A 2018 Merger Watt [sic] report found that the 12 largest systems then controlled half of all the acute care hospitals in New York and 70 percent of the inpatient acute care beds, and that situation is even worse now. The Truth is that we have allowed the corporate sensation of healthcare result in mega systems that have accumulated multiple hospitals and assets. They in turn have only continued to shift the healthcare delivery system in their favor. So, as a state legislator, thank you again for having me here. I'm ready to work with the City Council, our fabulous Chairwomen and hopefully a new City Hall to right this wrong, to turn this tide, to increase hospital capacity in Queens, a borough of working-class and immigrant communities, and ultimately I look forward to the day that I can cast my vote in favor of passing the New York Health Act which is carried by Senator Gustavo Rivera who I see his name here as well. So, really thank you and grateful to have me say a few words, and thank you for your work on the Health Committee and hospitals. Thank you.

CHAIRPERSON SCHULMAN: Thank you very much, and thank you for the accommodation. Really appreciate it. Thank you, Assemblywoman. Alright, so I have some questions for you guys. So, what kind of changes in staffing would Bellevue need to accommodate the estimated rise in patient levels if and when Beth Israel closes?

CHIEF MEDICAL OFFICER LAVICOLI: I mean, again, we're assessing what the exact impact would be. Bellevue knows and all of our hospitals know how to scale up when volumes increase. We did it during COVID. We do it on a day-to-day basis based on time of day, based on day of week, and we will scale up and accommodate whatever the increase in volume will be.

CHAIRPERSON SCHULMAN: I know there was discussion earlier about the health impact statement and the state and all of that. so, the fact that we're asking these questions at the end stage as opposed to the beginning stage of when this process was started is really a problem, and so not for you, but I'm just saying that that's why it's so important to get engagement at the front end instead of the tail end, because we're going to suffer for that.

H+H is going to suffer for that. So, does H+H presently have the funds to hire more nurses and doctors and other staff? I know you're not Doctor Katz.

CHIEF MEDICAL OFFICER LAVICOLI: Yeah, no, no, no. I mean, what I will say is, you know, reiterating just what I had mentioned before about our commitment to build our workforce and train representatives of our communities that will serve our patients with the various initiatives that I already mentioned, and we fiercely recruit with our Docs for NYC, Nurses for NYC, Psych Docs for NYC, Mosaic program, and you know, try to recruit through initiatives such as the loan repayment, BH4NYC, and providing the Nursing Fellowship and Nursing Residency Programs. So we are committed to recruiting and building our workforce.

CHAIRPERSON SCHULMAN: Thank you. One of the conditions that the State Department of Health articulated in their approval for Beth Israel's closure was that Mount Sinai needed to pay for an expansion of Bellevue's emergency and psychiatric department services. Have Mount Sinai and H+H

discussed the exact dollar amount that will be invested into Bellevue's expansion?

COMMISSIONER MORSE: Yes, there is a commitment made by Mount Sinai should they close. Payments would be made over time. That is a public document that has been provided to the elected officials.

CHAIRPERSON SCHULMAN: Do you know the funding source for the--

COMMISSIONER MORSE: I do not have specifics but we can get you the document, no problem.

CHAIRPERSON SCHULMAN: Please. Yeah, and in which fiscal year would we see the full impact, do you know that?

COMMISSIONER MORSE: Again, it's in the document, and we will absolutely provide it to you to review.

CHAIRPERSON SCHULMAN: Do you have a sense of how Bellevue intends to allocate the money? Would it be expansion of the ED or something else?

COMMISSIONER MORSE: And again, it is in that document. It is very spelled out specifically in the document what the funding would be allocated

for and we are committed to enforce the commitment in the document.

CHAIRPERSON SCHULMAN: State Department of Health has conditioned the closure of Beth Israel on Mount Sinai's operation of a 24/7 urgent care facilities which would be enhanced by the availability of a CAT scan or an ultrasound. What kind of limitations on medical care do urgent care centers fact, and what is the process for an urgent care center to refer a patient who requires more intensive immediate treatment to a nearby hospital and emergency department?

CHIEF MEDICAL OFFICER LAVICOLI: New York City Health + Hospitals doesn't have standalone emergency departments, and I will pass that to Doctor Morse to speak more about standalone emergency departments.

COMMISSIONER MORSE: Yes, for-- the New York City Health Department also doesn't run any standalone emergency departments or urgent care centers, but I understand your question around what is required for the closure plan for MSBI to ensure that there are still emergency services. What we can say generally about urgent care facilities is their

hours are not always as expansive as emergency departments that are 24/7, and urgent care centers vary widely in what insurances they accept, including Medicaid. They also vary widely in the level of specialty care that they offer in the urgent care centers, and so in general, we-- you know, we know that there are differences in the care offered at urgent cares as opposed to emergency departments.

CHAIRPERSON SCHULMAN: There's a lot of emergent data that suggests that people across the United States are turning to urgent care clinics more frequently, particularly for individuals who do not have a primary care provider and even for those who do have a primary care physician, appointments can be hard to find. Do you have any data specific to New York City and whether there is an increased reliance on urgent care centers, and if so, the reason for this trend?

COMMISSIONER MORSE: In general, many urgent cares were opened, because again, there are payment incentives to open urgent care centers. They are, however, a critical point of access to care for people who need healthcare. So, they are a part of the infrastructure for healthcare delivery in the

City. I do not currently have any specific urgent care data that you requested, but we can follow up with you and share what we do have access to in terms of urgent care data.

CHAIRPERSON SCHULMAN: There was a time at H+H, because I worked at H+H from 2007 to 2017, that they were considering doing standalones. Is that not the plan anymore?

CHIEF MEDICAL OFFICER LAVICOLI: We currently have the 24/7 virtual express care, and that is the urgent care equivalent for New York City Health + Hospitals. It is a virtual forum.

CHAIRPERSON SCHULMAN: It's virtual. It's not--

CHIEF MEDICAL OFFICER LAVICOLI: [interposing] Yes.

CHAIRPERSON SCHULMAN: It's not a brick and mortar.

CHIEF MEDICAL OFFICER LAVICOLI: Correct.

CHAIRPERSON SCHULMAN: any plans for a brick and mortar, or no, to your knowledge?

CHIEF MEDICAL OFFICER LAVICOLI: I would have to get the answer to that and let you know.

CHAIRPERSON SCHULMAN: Most urgent care centers, because-- sorry, let me go back for a second. The reason I'm asking that is because it's better to have them be part of H+H ultimately as opposed to an urgent care center where you don't know where they're going to go, and they're going to just wind up maybe in the ED or something else. Most urgent care centers are not run 24/7. While most are open on weekends, they are often closed at night. Obviously medical needs do not suddenly disappear to only return during the hours of an urgent care's operation. Do you have any specific data on the number of urgent care centers that are run 24/7, and do you think that increasing this number would have a measurable impact on the number of visits to emergency departments or hospitals across the City?

COMMISSIONER MORSE: We can share in follow-up the data we have about the number of urgent cares versus not. So, we can get back to you with that information, but in general urgent cares are not a replacement for emergency departments, and again, you know, the ripple effects of any hospital closures are somewhat unpredictable, but again, are clearly

that the people in the community that are using that hospital will have to seek care elsewhere.

CHAIRPERSON SCHULMAN: Right. The Department of Health's conditional approval only requires that Mount Sinai run the 24/7 urgent care clinic for three months following the formal closure of Beth Israel. Do you think that that time frame is sufficient?

COMMISSIONER MORSE: I'll pass that one to Doctor Lavicoli.

CHAIRPERSON SCHULMAN: What?

COMMISSIONER MORSE: I said I'll pass that one to Doctor Lavicoli.

CHAIRPERSON SCHULMAN: Okay.

CHIEF MEDICAL OFFICER LAVICOLI: I mean, I would say that-- again, I'm just going to echo again what I said before. We have our virtual express care that is 24/7 to accommodate once the-- you know, if and when the Beth Israel urgent care does close, and our facilities will accommodate any inpatient increase in volumes.

CHAIRPERSON SCHULMAN: If Mount Sinai's eye and ear infirmary closes in order to make room on that campus for 24/7 enhanced urgent care center,

would Bellevue or the Roberto Clementi Gotham Health Center be able to appropriately absorb any patients who would have otherwise gone to the infirmary for assessment or treatment?

CHIEF MEDICAL OFFICER LAVICOLI: Yes, we will scale up and accommodate any increase in volumes and I will pass it to Doctor Morse if she wants to add anything.

CHAIRPERSON SCHULMAN: So--

COMMISSIONER MORSE: [interposing] Thanks for that. The only other comment I would add is just that specialty care is harder to staff. The workforce is often more limited. The resources for specially can be more limited, so again, the impacts of specialty care closures specifically whether it's eye and ear specialized care or kidney transplant can be more challenging to address.

CHAIRPERSON SCHULMAN: So, I'm going to just go back for a second to line of questioning from-- that was started by Chair Narcisse. So, I just want to understand. So, the health equity assessment from the State, they're not required to share that with you, is that correct? They occasionally--

COMMISSIONER MORSE: Sure, I can-- I can describe that a little bit more. So, there is a process that's run by the State Health Department--

CHAIRPERSON SCHULMAN: [interposing] Right.

COMMISSIONER MORSE: PHHPC Committee, called the certificate of need process.

CHAIRPERSON SCHULMAN: Right.

COMMISSIONER MORSE: In the certificate of need process, there are some certificates of need that have to have a health equity impact assessment that the State Health Department would review as they're making-- as PHHPC is making decisions to approve the hospital change in services. That health equity needs assessment is often completed by either consultants or the hospital staff that have put forward their certificate of need, and in some cases the State Health Department asks us, the New York City Health Department, to review the health equity impact assessment and comment or add any additional context for the health equity impact assessment, but it's not required.

CHAIRPERSON SCHULMAN: So, would you have a problem if they came to you for all of these

assessed-- for all of the CONs that they had-- New York City DOHMH?

COMMISSIONER MORSE: I can't really comment on whether or not the State Health Department should or could do that. It's really their decision if they would want to--

CHAIRPERSON SCHULMAN: [interposing] No, I understand it's their decision. I'm asking if you would have the capacity, because it sounds like a bifurcated process at this point. They make the decision whether they do it, they don't do it. Do you also have an idea of exactly what CONs they do it for and don't, or is it just like whatever they feel like?

COMMISSIONER MORSE: Yes, that is described in the regulations and the rules for the health equity impact assessment process in the certificate of need. We can follow up with the specifics for you.

CHAIRPERSON SCHULMAN: Would you, please? Because we want to really take a deep dive into this to see what we could make better. And they're not-- so the New York State DOH-- so, if there's a closure,

they're not required to share that information with DOHMH?

COMMISSIONER MORSE: That's correct. If there's a full hospital closure, they're not required to consult us.

CHAIRPERSON SCHULMAN: Alright, we'll we're--

COMMISSIONER MORSE: [interposing] And they--

CHAIRPERSON SCHULMAN: [interposing] We need to change that.

COMMISSIONER MORSE: Or do a-- or a health equity impact assessment.

CHAIRPERSON SCHULMAN: We need to change that. So, we're going to try to work, Chair Narcisse and I and the staff, we're going to try to work on that, because that's inappropriate. That's not going to fly. So, thank you very much, and I want to turn it back over to Chair Narcisse. Chair Narcisse, thank you for the accommodation earlier, and then we'll go onto other colleagues. Thank you.

CHAIRPERSON NARCISSE: Okay. Chair Rivera?

COUNCIL MEMBER RIVERA: Thank you so much to the Chairs of the Committee for the time and for holding this hearing, and of course, to both of you for your expertise and for answering our questions. Can you tell us what are the most significant healthcare access issues that exist in New York City at this time?

COMMISSIONER MORSE: Thank you for the question, very expansive question I would say.

COUNCIL MEMBER RIVERA: Well, try to be as concise as you can.

COMMISSIONER MORSE: I would say that some of the big challenges that we see are the drivers that have led to life expectancy being lost in New York City over recent years. We developed and launched the Healthy NYC campaign under Commissioner Vassan in partnership with the Chairs, and that campaign outlines seven main areas of life expectancy drivers. So I was-- I'll just list them very briefly, because I do think they cover some of the most important areas for both public health and healthcare action. So, it's around cardiovascular disease, we look to reduce the rates of cardiovascular disease by 2030. We also are looking

to reduce the screenable cancer mortality rates. We're looking at Black maternal mortality which is one of the highest rates in the country. We also are specifically looking at COVID-related mortality as a key driver, and then we're looking at gun violence-related mortality, and then finally overdose deaths. So, those seven areas are the biggest drivers of preventable mortality and are the biggest causes of the lowered life expectancy that we've seen in New York City. So we see lots of opportunity for partnership in action for healthcare access and beyond in those seven areas.

COUNCIL MEMBER RIVERA: So what are the most important lessons about healthcare infrastructure in New York City that were learned as a result of the pandemic?

COMMISSIONER MORSE: I would say that there are a lot of learnings across the City. there was an after action report from the pandemic that was-- that is being published or in the process of being published by the City that describes a lot of the learnings for the Health Department, the New York City Health Department specifically. One of the things that we have been working on is response

readiness, and that means that we have the infrastructure we need, whether it's related to respiratory viral season or other areas to make sure that we are prepared for future disasters whether that's related to climate or pandemics or other things. I will also comment that SUNY Downstate specifically has a hospital preparedness program that we see as critical hospital readiness and emergency preparedness infrastructure for New York City, and so that is also a noteworthy area of infrastructure. And I will pass it to Doctor Lavicoli to share a little bit more from her perspective.

CHIEF MEDICAL OFFICER LAVICOLI: So, I am emergency medicine physician, but also emergency management, and I was at the helm of Elmhurst during wave one and then ran emergency management for the system subsequent to that wave. And I would say that COVID really highlighted that disinvestment in public health really made the cracks that were in public health into huge valleys, and we owe it to our communities to really invest in public health in the public health system. just to remind everybody that New York City Health + Hospitals is the second largest public health system in United States, second

to the VA, the largest municipal health system in the United States, and Elmhurst itself within the system has the largest number of uninsured and under-insured patients, and this is our mission to support our communities.

COUNCIL MEMBER RIVERA: And I thank you for that because this is-- really, you're going to hear from so many advocates in this room and other health professionals and your colleagues in other institutions here. I mean, having a response readiness, hospital readiness program inside of hospital that could potentially close, and then having hospital closures while we're looking at cardiovascular needs and cancer screenings and maternal care, COVID-related illnesses, gun violence, overdose, I mean these are all, I feel, very, very important issues that we have to work on in terms of expanding access to healthcare. And I'm very thankful to Health + Hospitals. I'm very thankful to New York Presbyterian downtown who has delivered excellent care to my constituents as well. You've said that ER visits are up across the board, and that's very, very scary for us in my district knowing that an emergency room, a department, is closing. I

know you don't have a standalone emergency room. I know you don't even have urgent cares. I thought you had one at Elmhurst, but did it close?

CHIEF MEDICAL OFFICER LAVICOLI: We had a brick and mortar prior to the COVID pandemic. Needed the space during the COVID pandemic, so--

COUNCIL MEMBER RIVERA: [interposing] Right.

CHIEF MEDICAL OFFICER LAVICOLI: went virtual, and since then it has been, you know, patient care space for, you know, hospital-- for the hospital.

COUNCIL MEMBER RIVERA: I know that you don't operate these facilities anymore or have ever, but can speak to the efficacy of standalone emergency rooms in urban environments? The data that we've seen-- and this is in the conversation I actually had with Doctor Katz, is that many people had doubts about their efficacy actually, and even the one that happened at St. Vincent's, but that they've actually proven to be beneficial and a good move in terms of setting up that infrastructure in communities. Can you speak to the efficacy of those rooms at all?

CHIEF MEDICAL OFFICER LAVICOLI: Since Health + Hospitals and does not have standalone emergency departments, I can't speak to it. I will pass it to Doctor Morse if she has further information.

COMMISSIONER MORSE: We'd be happy to follow up with some research data summarizing the impact and efficacy.

COUNCIL MEMBER RIVERA: Can I just-- Madam Chair, can I get a couple more questions, because the buzzer went off?

CHAIRPERSON NARCISSE: If you can wait for a minute, because there is a problem I'm facing right now. Senator Myrie got to run, been waiting.

COUNCIL MEMBER RIVERA: Okay. Bring him on.

CHAIRPERSON NARCISSE: And if we can allow him and then ask your kind permission to get him to make his statement because Downstate is in his district.

COUNCIL MEMBER RIVERA: Yeah.

CHAIRPERSON NARCISSE: So I'm going to reroute [sic] it--

COUNCIL MEMBER RIVERA: [interposing] As long as he knows that he owes me.

CHAIRPERSON NARCISSE: Yeah. So, no, but you can ask your question, because I'm asking--

COUNCIL MEMBER RIVERA: [interposing] Great. Alright, then.

CHAIRPERSON NARCISSE: I'm going to have to reset somehow, because that's his district that have Downstate. Is that okay with you both?

COUNCIL MEMBER RIVERA: Alright.

CHAIRPERSON NARCISSE: Thank you so much for your honorable-- thank you. So, we going to--

COUNCIL MEMBER RIVERA: Patience is a virtue.

CHAIRPERSON NARCISSE: if you can sit on the side and I don't know how the Sergeant going to do it. I'm doing something out of-- because we have to get Senator Myrie to speak, and then can they [inaudible] and reset again? Is that something you-- I know I'm giving you something new. One second Senator Myrie, because we're trying to understand what the rule. I don't want to break rules while we're trying to help. Senator Myrie. Can you give us one minute, because it's become like everybody

want to go, and then in the meanwhile I have to be respectful to those two honorable in front of me, too. Yeah, so give me a second. Let's try to wrap it up first so we don't have to close all the--

COUNCIL MEMBER RIVERA: Alright, I'm going to be brief then, I guess.

CHAIRPERSON NARCISSE: Be brief.

COUNCIL MEMBER RIVERA: Alright, I appreciate you. How will the loss of a full-service hospital affect the ability to treat mental health needs, including mental health emergencies, chronic needs, and inpatient mental health? You mention this in your testimony which is why I'm asking.

COMMISSIONER MORSE: Yeah, thank you for the question. Particularly, again, because of the high rates of overdose and other mental health needs and the mental health plan that the New York City Health Department released, this is a priority area for us. Mental health diagnoses are a common cause of emergency department visits and hospitalizations. So the same kind of analysis applies from our perspective. Any hospital that closes means that he ripple effects will be the community seeking care there, including mental health care, will be forced

to look to other hospital and clinics in that neighborhood to get their care, including mental health care.

COUNCIL MEMBER RIVERA: And my last question is, I know that you're prepared to scale-up. I highly respect that. I've been told that by Bellevue and by Health + Hospitals, and we always appreciate the way that our public healthcare system steps up. With the pending closure of MSBI, what concerns are there about the gap in hospital services this will create for community members and other New York City residents who have received primary care ED, ambulatory, and inpatient services there? 70,000 emergency visits a year.

CHIEF MEDICAL OFFICER LAVICOLI: Yeah, the commitment that is made between Mount Sinai and Health + Hospitals, there will be support of the emergency departments of behavioral health. They are actively looking to create more inpatient beds. So all of this is being looked at very closely, and actively being worked on.

COUNCIL MEMBER RIVERA: Well, even if, you know, you can't expand, I know you can have the physical capacity to take on more patients. However,

you would have to make some infrastructure upgrades like renovation and expansion, and even if the money was there today, you wouldn't be able to do that overnight in time for the closure. So, I mean, we remained deeply alarmed in my community. I appreciate your support as we move towards I think a more transparent process and we're thankful to our state colleagues for putting forward legislation that we hope will require more community input should something like this happen again. I want to thank all the advocates who are here fighting to keep services available, and of course, accessible. Thank you.

CHAIRPERSON NARCISSE: I know we have to run, but I have some question I want to ask. Given the severe strength of COVID-19 placed on our healthcare system, particularly in terms of hospital capacity, shouldn't we take that in consideration before we close. I know you-- it's the state. Shouldn't we take that in consideration before we close any hospital?

COMMISSIONER MORSE: I can't comment on the state's process for how they-- what information they used to decide or to analyze and consider a

hospital closure and whether or not it would be approved, but I can say that we have published-- the New York City Health Department did publish a study that is open-access and freely accessible to the public that describes the impacts during-- of the surge inpatients during the first wave of the COVID-19 pandemic that also has our analysis and recommendations around that issue.

CHAIRPERSON NARCISSE: Alright. And call for action I would think if-- I hope you can stay a little bit, because I have to call the Senators. It has to be a comprehensive planning. It has to be community engagement, because they're going to be effected. It has to be the folks that working in the hospital, the healthcare providers, the doctors, the nurses knowing the impact and the people that they've been seeing. I understand the culture for so many decades. So, I'm saying like you have the voice where you're sitting, so we're going to have to come with a comprehensive planning for the-- for New York City if anything. So, I hope you can step aside. I hope we can come back, but I'm not going to force you to do so, because you're not going to do that, but if you can, if you can kindly-- you have a little

minutes you can spend with us, I would appreciate that, because the Senator that are affected by the same hospital we're talking about will be coming. So thank you so much for you time. And Council-- oh, one second. Councilman-- I mean Councilwoman Joseph says she has question for you. So you going to wait for us. Let me-- tell me. If you can't wait, because they have about four senators. You can come back? Can you give us a little extra time, is that possible? Yes? Oh, I appreciate you. So we can let the panel come and we-- that's-- Council Member, is that okay? You get your senator? That's your senator, right, your district? Alright. So thank you so much, and we're going to--

COMMISSIONER MORSE: [interposing] Thank you.

CHAIRPERSON NARCISSE: thank you.

CHIEF MEDICAL OFFICER LAVICOLI: Thank you.

CHAIRPERSON NARCISSE: Thank you. I didn't want to do it-- I would like to call all of my honorable at once that can come. Assembly Member Harvey Epstein, Assembly Member Jo Anne Simon, Senator Zellnor Myrie, Senator Gustavo Rivera on

Zoom, and I believe Catherine is here on behalf of Senator Christen Gonzalez. Did-- everybody left me, or some folks are here? Okay, Senator Epstein left testimony in writing. We'll review that later, but let's begin, because Senator Jo Anne Simon, I mean, Assembly Member.

ASSEMBLY MEMBER SIMON: Thanks for the promotion.

CHAIRPERSON NARCISSE: Assembly.

ASSEMBLY MEMBER SIMON: thank you very much. I'm Assembly Member Jo Anne Simon, representing the 52nd AD in Brooklyn. I wanted to thank chairs Narcisse and Schulman for this opportunity, and Councilwoman Rivera, for your support for the LICH Act and the resolution. So, let me just say that this bill that we passed we passed in both houses, the Local Input to Community Healthcare Act, it is born out of my experience as a community leader when Long Island College Hospital was closed, and that was closed in 2013. And I've been fighting ever since that time to have hospital closure be a process that makes sense, because it doesn't right now at all. So this bill, this particular bill which awaits the Governor's signature would require public notice, and

that would be to Community Boards, to various elected officials, various entities throughout the state, obviously, and community engagement when a hospital seeks to either close the entire hospital or close a unit that provides emergency, maternity, mental health, or substance use care. And there's a particular reason for that. As you may know, maternity departments, there have been 10 maternity departments in New York State that have closed in the past decade. If you live in certain parts of the Hudson Valley, for example, you have to go to Troy to deliver. It's an hour or more away. So, we have-- this is a big issue in the state. So, you can see here in the City, obviously it's very easy to see how there could be local impacts, but it's also a big issue for community hospitals in various parts of the state. Now, LICH was a victim of the Berger Commission, and one of the things we learned through that process, of course, that the community had no means for input, right? The community kept raising certain issues, but we were basically told it didn't really matter. There was really not data that would support the community's concerns, but the reality is that we were told various happy talk, various talking

points. Nobody goes to LICH anymore. Everybody goes to Manhattan. That was not true, and this served the communities of Red Hook. It was a federally designated healthcare emergency location, and we had people die because the ambulances when they switched from LICH's ambulances-- because they couldn't find the addresses within Red Hook Houses, because they weren't familiar. If you're familiar with public housing, very often the addresses don't make a lot of sense, right? And so time is of the essence, and we were really literally losing people. So there's no public hearing required to close a hospital right now. The only thing the law requires is a public hearing 30 days after the closure decision is made, which is a little too late-- too little too late. And if I can just wrap up. There is some community engagement now with regard to regulations and guidance from the Department of Health, but that's only regulatory and it doesn't apply to hospital closures. And so I just wanted to say that, you know, the LICH Act when it's signed will in fact require the engagement and the notice to communities that you have been talking about. So, I thank you for this opportunity.

CHAIRPERSON NARCISSE: Thank you so much for being here. And Senator Myrie?

SENATOR MYRIE: Thank you to the Chairs of the Committees, Chair Narcisse, Chair Schulman, and to the members of the relevant committees. I am here in my capacity as a State Senator representing the 20th Senatorial district. I represent SUNY Downstate, but I also am speaking as a New Yorker born in a safety-net hospital. I was born at what is now known as Interfaith Hospital in Crown Heights. Hospital are anchors in the communities that they serve, and they provide healthcare to everyone in a community regardless of income or status. They also know the cultural needs of the communities that they serve. It follows then that hospital closures have ripple effects for the entire community. Jobs are lost. Access to affordable and quality care is reduced, and trust is diminished by disinvesting in the community. It's a story that's been tragically repeated over and over, and we've heard a number of those tragedies here today at this hearing. But in my community in central Brooklyn, there's a plan to close SUNY Downstate, an institution that served our community during the darkest days of the pandemic

that houses the only kidney transplant center and one of two regional perinatal centers in Brooklyn. The proposal included a "public outreach process" that was rushed, opaque and wholly insufficient. There were closed-door invitation-only focus groups and a last-minute report thrown together that summarized its preordained conclusions. It was frankly an insult to my community, and I am proud that we mobilized to fight back against this plan. I'm also proud to be a cosponsor of the Local Input and Community Healthcare Act sponsored by my good colleague Jo Anne Simon which passed both houses of the legislature this year and that will hopefully be signed into law soon. As she just said, this bill will put into place new public engagement processes when a general hospital seeks to entirely close or shutter a unit that provides emergency, maternal, mental health, or substance use care services, services that are particularly essential in communities like the one I represent. Ever since COVID there's been a dramatic decrease in availability of mental health care and psych beds, and the maternal healthcare crisis is especially dire, with Black women in Brooklyn more than nine

times as likely to die in childbirth as their white counterparts which is why I was pleased that this Council recently passed a resolution endorsing the Chisolm Chance Act, a bill that I sponsored, which recognizes and seeks to address this maternal health crisis facing Black and Brown communities especially in Brooklyn and the Bronx. Our hospitals are critical pieces of community infrastructure, and we must demand transparency, true community engagement and partnership when a facility plans to close or reduce service. So I'm grateful to the Council for taking a stand for public health by formally endorsing this important legislation and for holding this hearing today. Thank you.

CHAIRPERSON NARCISSE: Senator Rivera on Zoom?

SENATOR RIVERA: Good afternoon everyone. Good afternoon Chairwoman Narcisse and Chairwoman Schulman as well as my colleagues there. A lot has been said already. There's a couple of things that I'll just add. You have my written testimony. There's a couple things that I want to add. Number one, certainly there is process right now for closing hospitals in the State of New York, but unfortunately

it is one that does not take the community's input into account and in all honesty leaves the state with little teeth to be able to enforce when they believe that it is not something that should happen. Everything that we've heard today talked about the need of these hospitals and these institutions across the state. So I wanted to just speak for a couple of minutes about some of the things that I believe we can do. first of all, as it relates to those closures, as we said, the bill that sponsored by Assembly Member Simon and myself in the Senate passed basically unanimously and now waits for the Governor's signature, and I certainly thank you, the Council, for joining us and continuing to encourage the governor to do the right thing and sign this bill into law. But second, something that was mentioned by one of my colleagues, Assembly Member Gonzalez-Rojas, there is-- there's a larger bill, the New York Health Act, would actually go a long way towards solving a lot of the problems that we got-- that we have that make some of these closures supposedly necessary. I mean, when we think about the fact that you have institutions are considering whether they are-- the primary motivator is profitability, and

that's because of the way that the current system is organized. So it's kind of one of those things where even good actors are stuck in a place where they have to put institutions in places where there are more private payers than Medicaid patients, because as I've said many, many times over the last 15 years of me being in the Senate, what has become clear is that institutions who treat Medicaid patients basically lose money every time somebody walks in the door. And ultimately, because we have a system that is built on profitability. Even institutions who want to provide for their-- for Medicaid patients have to figure out how to make some level of money to be able to stabilize themselves. And but there are things that we can do. Certainly passing the New York Health Act as a big piece and eventually something that I hope that we will do, but there's other things that we can do. we have one bill for example that I have that would provide comprehensive insurance to all individuals that is regardless of their immigration status by getting federal money to provide that, to provide the essential plan to undocumented folks which would take a lot of money that is currently being spent by the state as

emergency Medicaid and we would get it from the federal government. That is coverage for all. That is something that we can do that will give the state and the city money by making sure that institutions who serve many undocumented folks, they actually will get-- they will actually have the essential [inaudible]

SERGEANT AT ARMS: Your time has expired.

SENATOR RIVERA: And there's a couple of other bills that I looked forward to speaking about. Thank you for the invitation. I didn't know how much time I had, so I was trying to hurry up. Thank you.

CHAIRPERSON NARCISSE: Thank you, Senator. Now, we want to hear from Katherine Demby from Senator Kristen Gonzalez.

KATHERINE DEMBY: Hi, my name is Katherine Demby and I'm representing State Senator Kristen Gonzalez who represents parts of Manhattan, Brooklyn, and Queens. Representing three boroughs makes it abundantly clear the hospital closures are never isolated incidents. Over the past decade several hospitals have closed across our city while critical services have migrated towards wealthier neighborhoods and working-class New Yorkers have been

stranded in healthcare deserts. Now more than ever, we must protect our community hospitals and prioritize healthcare access for the most vulnerable New Yorkers. As you've heard today, hospital closures can devastate communities, even while they're still ongoing. So much of this devastation comes from the lack of meaningful community engagement from those who will be most impacted by hospital closures: elderly people aging in place, people with disabilities, poor and indigent people, workers, and families. But we don't just need community input, we must put that input to good use and give communities the resources they need to protect healthcare access for everyone. That's why we also need robust regional healthcare planning, Medicaid parody and more supports for safety-net hospitals to build a healthcare system that works for everyone. Thank you to the City Council, to Council Members Narcisse and Schulman, for shining a light on the current crisis in our healthcare system. The Senator looks forward to working with her colleagues to support critical legislation like the LICH Act and to ensuring that all of our communities have the high-quality healthcare they deserve. Thank you.

CHAIRPERSON NARCISSE: Thank you. Senators-- what phase you were aware that the Downstate, you were planning to close Downstate?

SENATOR MYRIE: We were told that Downstate was closing the week of Martin Luther King Day in January. We were presented the plan as a so-called transformation plan. The state communicated to us that this was a plan that would go on the Governor's Executive Budget, and so we were given that amount of time from January until the budget concluded to figure out what the response to that plan would be.

CHAIRPERSON NARCISSE: What bothers me the most is just the investment in our hospitals that in the Black and Brown communities, because I've mentioned that before about 15 or something, 16 years ago. I was in front of Downstate. So, what happened during budget season that those investment were not being addressed? What happened?

SENATOR MYRIE: And I of course welcome my colleague to au pine as well, but the fight for Downstate is not a new one. It is, in fact, emblematic of the fight for healthcare equity in the City for decades. It is unfortunate that we have

alumni of previous fights to keep Downstate open because we have year after year after year had to fight for investments. We're talking about a hospital that out of its control was designated a COVID-only hospital by the previous Governor. As a result, lost patients, lost revenue, and was in fact cut during the COVID years through the Executive Budget. To then come forth with a plan not to give it the money back that it lost, not to invest back in the community that served during the darkest days of the pandemic, but in fact to close it down, was a complete slap in the face to the community. It's why we fought so hard, and I want to-- and I give kudos to the Chair of the Health Committee as well, my colleague Senator Rivera, who stood really strong on this and said the only state-run hospital in the entire city cannot be subject to this type of treatment. It's why we came up with a plan during the budget to have a commission, an advisory board that would determine the future of this institution. I am sad to report that that board has not yet been convened and we have a decision to make by April of next year, and we might be in the same situation that

we were in last year. So, it is important for us to get on it and to get on it now.

CHAIRPERSON NARCISSE: To me, I think it was strategically planned. So, that's my own opinion. Senator Rivera, I think you had your hand up?

SENATOR RIVERA: Yeah, I do. And if possible, if I could be just left unmuted. I'm not going to chime in on everything, but I just would like to not have to do it every time. The fact is that this is something that is consistent, you know, with institutions across the State. This is not just-- certainly, we're talking here in the City of New York and we're talking about SUNY Downstate in particular, but this is something that is consistent with institutions across the state of New York for as long as I-- my tenure in the Senate has been 15 years, been the Chair of the Health Committee for just about six or seven-- six of that. It's been a long time. But basically, every single budget year there is a battle about Medicaid rates and Medicaid rates mean institutions that are safety-net institutions that serve places just all across the state, not just in urban districts, but certainly in rural districts and other parts of the state. They

are underfunded by default. The state knows this and does nothing long-term to fix it, and that's the real problem. The issue here is that the-- what you're saying that they are-- that it was kind of planned, it was-- I wouldn't-- I wouldn't actually-- I wouldn't be surprised if that was indeed the case, and when we look over there, when we look at the institution, it is not an institution that is falling apart. It is institution that is doing the best with the limited resources that it has, and yet the state is saying we're just going to close it without any real concern for the impact that it's going to have in the community. I certainly thank Council Member-- I'm sorry, senator Myrie and everybody who's on the dais right now who spoke up loudly and said this is-- we don't want to have this to happen, but again, it is a consistent thing in the system in the state of New York that the state knows is the case. It is consistently underfunded. These institutions are falling apart through no fault of their own because of who they serve, and yet, the state does not have a long term plan here. There are long-term solutions, but unfortunately it's always short-term and [inaudible].

CHAIRPERSON NARCISSE: Thank you. And for the hospital, if you use the hospital for COVID place, first of all, it takes a lot of time for people in our culture to go back to that hospital that have other problem they're facing. So, therefore, if after that there is no big investment after you use the facility for COVID patients, it takes time for people to get back, to get used to the hospital and no money was coming. But anyway, I know I'm not going to win with this. As a nurse, I kind of like get it personal. So, my colleague, Rita Joseph, I know that's your-- you have any question? That's the hospital in your district, too.

COUNCIL MEMBER JOSEPH: I sure do. Good morning. Thank you, Chair. Good morning, panel. Thank you to my Senator for being steadfast with leadership on SUNY Downstate. So at the end, what's the vision for Downstate, and what is the state doing to make sure that we preserve and not close the doors on Downstate?

SENATOR MYRIE: Thank you, Council Member, and you are my councilwoman as well. So, thank you for your continued service to our district. The plan is that we should have world-class

healthcare services just like everybody else, period. We hate having to come to the state and beg every year. Let's make the real investment up front. Let's have a world-class women and children's hospital in the center of the maternal health crisis. Let's continue to provide kidney transplant services to a constituency that needs it desperately. Let's work on eradicating asthma in our communities. Let's step up and do something big. This is the only state-run hospital in the entire City of New York. The State should be embarrassed that we have to keep coming back every year on this. So, I am looking forward to being in the fight, not just with my colleagues in the state, but with all of you so that we can show what government can do when we care about the people we represent.

COUNCIL MEMBER JOSEPH: Thank you. Know that you have a partner as well and you have us as-- on the city level to support you. One other-- you mentioned the commission. What is the status on the commission? And I know there was supposed to $100 million given to Downstate. From what we understood there's a down payment of $20 million, but they still haven't stepped up and give up the other $80 million.

SENATOR MYRIE: And I'm going to shout out my colleague, Assembly Member Simon as well. She joined me in writing a letter to the Executive Chamber to request what the status of this commission is. The unfortunate truth is that we don't know. It has not yet been officially convened, and that is troubling given the time constraints that the statue has us under, and I don't know if the Assembly Member wants to add to that.

ASSEMBLY MEMBER SIMON: yep, there we go. So, thank you, and thanks Senator Myrie for his incredible leadership on this and all of you for your support. you know, one of the things we tend to do in the budget is that because there's a budget crunch we make decisions-- we make decisions based on some sort of negotiation, but very little data which is one of the reasons why we wanted the LICH Act because it would provide us with that data of impacts, not just data on the number of beds, but the actual impacts. And so the problem with this commission is when I first heard about this they invited us to dinner. A bunch of heard that they were not going to be able to stay open because they had too much debt, and that debt is primarily because of the physical

plant, right? There's been no investment in the infrastructure or very little. Some parts of the hospital are in great shape, some parts are in terrible shape, right? And so the state hasn't invested, and then the state goes, oops, we have no money. We're going to have to sell it and do something else. And they have here a struggling hospital, and they were planning on kind of just pushing everything over to Kings County which is also a struggling hospital. How long was that going to last? So, there's very little planning that actually happens. It's just sort of decision-making under-- in crisis all the time, and the more we can do to help create that vision, but also let-- we have a commission. Come on, let's have a meeting. Let's figure out what's going on. I don't want to find out about that meeting in January when we have a deadline, a budget deadline, of March 31st for an April 1st deadline.

COUNCIL MEMBER JOSEPH: So, this year, here's my commitment, not only going up to fight for education as the Chair. I'll be up there to fight for health and hospitals-- the hospital as well, so you have my full commitment as the Education Chair

here, but also having SUNY Downstate in my district. It's in my councilmatic [sic] district. So, I'll be up there. Albany, get ready. I'll be there. Thank you.

ASSEMBLY MEMBER SIMON: Thank you.

CHAIRPERSON NARCISSE: And I don't have to say anything. You know I've been there. I benefit from the whole structure. So, we need to continue fighting to address the inequities. So, I think before we finish, the one last question by Madam Chair.

CHAIRPERSON SCHULMAN: I have a quick question for you. So earlier in the testimony it was-- New York City Department of Health said that the state doesn't have to tell them when they're having a closure in New York City. So would you support us if we push for that?

SENATOR MYRIE: A thousand percent. I think this is in part what the LICH Act is getting at, but the truth is that they don't-- it's not just that they don't notify you, they don't notify anybody. None of us know, and that's the problem, that we could have such a critical institution in our communities be shut down or reduced without

notification and notice, and so we would be fully in support of that.

CHAIRPERSON SCHULMAN: Okay. Thank you very much.

SENATOR MYRIE: Thank you.

CHAIRPERSON NARCISSE: Thank you.

SENATOR RIVERA: And just to reiterate-- and just to reiterate that--

CHAIRPERSON NARCISSE: [interposing] Oh, you have one more thing?

SENATOR RIVERA: Yeah, just really quickly. This is precisely what the-- what the bill would do. it would create a process that would mandate community involvement from the beginning and would continue it along-- as well as an independent entity to assess the health impacts of particular closure, whether it's an entire hospital or section of the hospital, etcetera, but that's precisely why this bill is so essential which is why I again thank you, because we are-- it's October. The bill passed months and months and months ago, and we have consistently talked to the Governor's office and said do you want to have a conversation about whether you would sign this, whether you have potential changes

that you would like to make sure that you leave the core of the bill untouched, but we have not-- we have not heard back yet. Hopefully, we do, but I am certainly hopeful that all this pressure would mean that the Governor again does the right thing and signs this bill.

CHAIRPERSON NARCISSE: Since we cannot sign your bill, but we'll do raise [sic]. We'll do whatever it takes to make sure that we have that equity in healthcare in New York City. Thank you so much. Thank you. Appreciate you. Now, we bringing back our honorable, gracious panelists that we thank you for your time. Thank you. And I believe Chair-- Majority Whip Brooks-Powers--

COUNCIL MEMBER BROOKS-POWERS: Thank you, Chairs. Thank you for convening such an important topic and for the agency for being here on this important topic. So, the potential closure of Mount Sinai Beth Israel in Manhattan and SUNY Downstate in Brooklyn are not just institutional changes, they're potentially-- they're potentially life-altering events for thousands of New Yorkers, and for too long communities like ours have shoulder the burden of healthcare cuts and often leaving residents with no

alternative but to travel further and wait longer for essential services. This is something that I'm very passionate about, because it's something that we experience in Southeast Queens, whether it be the closing of Mary Immaculate Hospital or Peninsula Hospital. So I had a few questions that I really would love to get your insight on, and first, in terms of the impact on trauma services and patient access. How does the City assess the potential impact of hospital closures on trauma services and critical care access, particularly in underserved areas? Brooklyn very similar to southeast Queens. And I know earlier in your remarks you spoke about the state's role in that and not necessarily communicating that, but I'm curious is there any level of communication, and is there any space where the City can say wait, no, we actual need-- this is critical services that are needed here. And what are the plans in place to ensure that surrounding hospitals are equipped to handle the increased patient load when a hospital is closed or downsized, because that in itself could have an impact on city hospitals if there is-- if you're fortunate to have one nearby.

CHIEF MEDICAL OFFICER LAVICOLI: Thank you so much for the question. I'll start with the question around access to trauma services. That is something that we could follow up with more details around and are happy to share something more specific. The Health Department does run the city's hospital violence intervention programs where we partner with all the hospitals across the city, 11 hospitals total, that see the highest number of violence-related injuries and we work with them to do violence interruption services. So we do have some engagement with hospitals around violence prevention services and trauma services. However, it is still the State Health Department that is most involved in mapping capacity around things like trauma care, and it's a different kind of designation for the type or level of complexity that the trauma center can handle which is also not within the New York City Health Department's realm of control. But your point about the impacts of hospital closures on surrounding hospitals, again, is something that we are also concerned about even though it is not within New York City Health Department's realm of regulation or control. We did send a letter to our colleagues in

the New York State Health Department, Commissioner McDonald and his team, just stating some of the data that we looked at around the impacts of potential closure of SUNY Downstate and some recommendations to partner with them to continue the conversation. And even though we don't have any decision-making authority we do, you know, appreciate the opportunity that we had to send that letter stating our position in the New York City Health Department on what the SUNY Downstate closure could mean in terms of health equity and outcomes in Brooklyn.

COUNCIL MEMBER BROOKS-POWERS: thank you for that. and just in terms of exploring alternatives to closures, has the City's explored transition plans where hospitals facing financial difficulties are repurposed to serve specific community needs such as urgent care or specialized clinics instead of complete closures, and are there any examples of hospitals that have successfully shifted from full-service operations to targeted healthcare services and what lessons could be applied to New York City hospitals?

COMMISSIONER MORSE: We in the Health Department don't have that, but I'll pass it to Doctor Lavicoli in case she has some comments.

CHIEF MEDICAL OFFICER LAVICOLI: Health + Hospitals does not have standalone or urgent care that they operate. So yeah, we couldn't comment on that either.

COUNCIL MEMBER BROOKS-POWERS: But has the City explored any type of transition plan like considering that you all are monitoring when there are closures and that there could be a spillover impacting the City's hospital apparatus. Are there any like transition plans that the City may engage in to ensuring that New Yorkers are still able to receive the care whether it's sending information or what have you?

CHIEF MEDICAL OFFICER LAVICOLI: I mean, I can say that for Health + Hospitals we are, you know, putting into our-- emergency department's putting in to making more beds, putting and making more capacity in our outpatient clinics. We have a virtual express care as our virtual-- as our urgent care option and it's also a telehealth option. So, we are constantly creating more capacity and

upgrading in order to accommodate any volume increase for whatever reason it might be.

COUNCIL MEMBER BROOKS-POWERS: Chair, can I just ask one final question? How is the City working with communities to provide transparent information about potential closures and to gather feedback proactively?

COMMISSIONER MORSE: I can start by saying that a big part of our priorities and infrastructure and programs in the New York City Health Department is within the Center for Health Equity and Community Wellness, and within that center we do pretty extensive community engagement. We also fund community-based organizations and the information from those community engagements process also inform our community health profiles that we update regularly and are publicly available on the New York City Health Department website. So, those are the kinds of things that we do routinely as a part of our process to make sure that community voice and community priorities are a part of our planning. We haven't convened any specific forums in the New York City Health Department around this particular hospital closure, but we do have existing forums,

including work in Brooklyn on birth equity where we hear from community members about their concerns and integrate that into our planning. I'll pass to Doctor Lavicoli in case she'd like to add.

CHIEF MEDICAL OFFICER LAVICOLI: I have nothing further to add.

COUNCIL MEMBER BROOKS-POWERS: Thank you.

CHAIRPERSON NARCISSE: You're done? With over 1.1 million adults in New York State living with chronic kidney disease, particularly impacting Black and Hispanic communities due to social economic and healthcare access disparities. How will Department of Health and H+H will ensure those specialty services like those provided by Downstate if they close, which we'll not allow it, but then again, we have to be proactive. So, how-- what's-- I mean, Downstate, if that happen, which serve as the only kidney transplant facility in Brooklyn, remain available to meet these critical needs? So, how we going to plan this just in case, but which not going to happen?

COMMISSIONER MORSE: Yeah, we are very aligned on needing to prioritize access to specialty care, especially things like kidney transplant. For

the New York City Health Department we don't provide specialty care services like kidney transplants, so we're not a service-delivery organization in that particular area. However, we do see the opportunity to continue to raise awareness and partner with our healthcare delivery partners around, again, raising awareness about needs for access to kidney transplant. So even though we're not doing the service delivery, we do see it as a priority issue. And I'll pass it to our healthcare delivery partner in the City, Doctor Lavicoli.

CHIEF MEDICAL OFFICER LAVICOLI: So, Health + Hospitals does not have a kidney transplant program, but we do take care of patients in all of our acute care facilities with chronic kidney disease and have renal specialists available throughout our health system.

CHAIRPERSON NARCISSE: My question was not that you're providing the care, Department of Health, but if the folks in New York City, you have 1.1 in the state and you have a good portion in New York City, so we are part of the solution of the problem in the City. So how are we planning to make sure that those folks that need the transplant that

need the kidney, that suffering from whatever-- I'm sure including dialysis and all that. Are we planning something if that happens? How we respond to it? That's basically how we going to respond to that, because we all-- Department of Health play a key role, very instrumental in making sure that our needs in term of diseases are being approached.

CHIEF MEDICAL OFFICER LAVICOLI: Our facilities at Health + Hospitals are able to provide support for chronic kidney disease and dialysis patients as-needed on an emergent basis, but again, we don't have a kidney transplant program.

CHAIRPERSON NARCISSE: I think that's the time that we have to be proactive in planning, because those folks that suffer that need the transplant are going to be around-- just I mean, I'm saying we're going to fight, don't get me wrong. When we fight they say we win. That's what's happening. We're going to do that, but I feel like more planning strategically should be going on right now just in case if that happen, those folks that need the transplant, there's no stop in the care for them, because we need to continue providing the best quality healthcare in New York City. Having said

that-- Chair Rivera, you have any question? I am so grateful and thankful for you to be here and stay, especially we have to disrupt something and then you still collaborate with us. So I want to say thank you from the bottom of my heart, and let's continue pushing to make sure we provide care in New York City. Thank you.

COMMISSIONER MORSE: Thank you.

CHIEF MEDICAL OFFICER LAVICOLI: Thank you.

CHAIRPERSON NARCISSE: I now open the floor to public testimony. Before we begin, I remind all members here of the public that it is a formal government proceeding and that decorum shall be observed at all times. As such, members of the public shall remain silent at all times. The witness table is reserved for people who wish to testify. No video recording or photography is allowed from the witness table. Further, members of the public may not present audio or video recordings as testimony, but may submit transcripts of such recordings to the Sergeant at Arms for inclusion in the hearing record. If you wish to speak at today's hearing, please fill out an appearance card with the Sergeant at Arms and

wait for your name to be called. Once you have been recognized, you will have two minutes to speak on today's hearing topic regarding the effects of the hospital closure on community needs. If you have a written statement or additional written testimony you wish to submit for the record, please provide a copy of that testimony to the Sergeant at Arms. You may also email written testimony to testimony@council.nyc.gov within 72 hours of the hearing. Audio and video recordings will not be accepted. When you hear your name, please come up as the witness panel. For the first panel, we're inviting Chatodd Floyd, Andrew Title, Joan Rosegreen, Madeline Vilallaba, Judy Wressler. Sorry. Chatodd Floyd, you may begin.

CHATODD FLOYD: Alright. Good afternoon Committee Chair Schulman and Narcisse as well as 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, and I'm joined by my colleague Andrew Title, Vice President of Government Affairs. Greater New York proudly represents not-for-profit and public

hospitals, health systems, and continuing care providers around the tristate region, including 170 hospitals and health systems and 54 continuing care facilities in New York State. Greater New York is committed to ensuring that no hospital to close its doors. However, after years of struggling against insurmountable challenges, some hospital 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, 1199 SEIU, so hospitals can keep their doors open and provide quality jobs and New Yorkers can access equitable high-quality healthcare. We are grateful for the Council's 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 announcements for prominent hospitals and their closures plans over the past year, this is not a new situation for us. It is a byproduct of years of neglect and underfunding that has long-term led to cumulative Medicare cuts as well by the Affordable

Care Act. And today, I want to actually discuss why we are being forced to close. Hospitals do not close because they want to. They close because they are no longer financially viable, and some hospital simply cannot continue to operate in the red year after year without external help. These institutions are under fire today, and when help doesn't arrive, they are left with no choice but to shut down and cut back on services. As the Governor noted in her State of the State address in January, hospitals in New York are struggling financially more than the rest of the United States with 42 percent of facilities in New York having a deficit in 2021. What she did not mention was that figure rose to 63 percent in 2022, and we currently have a median operating margin of about 2.8 percent. Experts actually agree that hospitals require an operating margin of at least three percent to be sustainable. Simply put, we are operating at unsustainable margins here, and without such a margin, they cannot invest or reinvest in patient care, services, and hospital infrastructure such as the capital improvements in IT that's critical to provide high-quality healthcare. A fundamental issue--

CHAIRPERSON NARCISSE: [interposing] Can you try to wrap it up for me?

CHATODD FLOYD: Absolutely. The most fundamental issue is that Medicare payments are about 30 percent lacking behind the cost of care. So for every single facility or everything patient servicing Medicaid members, that were losing money outright. We want to make sure that we can address this. We want to thank you for the fact that you led the resolution last year to support. You know, we were able to receive four percent Medicaid rate increase from the state last year. Yet, that money has not actually gone out of the door. Often times, we are met with delayed payments and things of that nature, so even when help comes it's often too little too late and we're sort of kept on the margins.

CHAIRPERSON NARCISSE: Thank you. Now, we move to Andrew Title.

ANDREW TITLE: I don't have anything to say here. I'm just here to support Chatodd.

CHAIRPERSON NARCISSE: Joan Rosengreen?

JOAN ROSENGREEN: Good afternoon. Thank you for having me Committee Chair Mercedes Narcisse and other members of the panel. I'm simply as a

Registered Nurse who's currently employed in the emergency room at SUNY Downstate.

CHAIRPERSON NARCISSE: I think someone next to saying that she cannot hear. So if you can put the mic closer so she can hear, a little closer to you.

JOAN ROSENGREEN: As I was saying, I'm here as a Registered Nurse who is currently employed at SUNY Downstate in the emergency department. I've been there for the past 22 years, and I can testify firsthand to the impact that the closure of SUNY Downstate will have on the community. I live in the community. I left the City to come back to the community so I could serve the people who look like, and as you may or may not know, we have a high incident of diabetes, kidney failure, heart disease, hypertension. Our community, the minority community is impacted the most, and if this hospital is closed, then we call it-- I refer to it as medical suicide. My mother as I'm speaking to you [inaudible] is a patient in the hospital. I use the hospital for my entire family and I've had my treatment there. And I remember when my mother had a stroke, which we are a certified stroke center. She was taken there. She's

fully recovered and at 89 years old she has her mental capacity. Not only are we a transplant facility, we are one of the only hospital that offers pediatric dialysis. We are also a hospital that take care of people who are stemi [sic] and so I just want to emphasize that the closure of the hospital which is the epicenter of teaching hospital that you know, produces 90 percent of the doctors serving in this community, and minority doctors, too. It's going to be impacted tremendously by the neighborhood in and around. There's no resource for those people to travel to the City if they have a stroke. By the time they get there, they'll be flat-lined, meaning they'll be dead. So, I implore all parties involved to ensure that we keep our hospital in our community so that we can continue to offer the services that we offer to those who are underserved. Thank you.

CHAIRPERSON NARCISSE: Thank you. Next is Madeline Vilallaba.

MADELINE VILALLABA: Okay. Can you hear me? Okay. Chair Narcisse, Chair Schulman, Council Member Rivera-- oh, okay thank you-- and other Council Members, thank you so much for the opportunity to speak. My name is Madeline Vilallaba.

I'm a medical student in East Harlem. I spend a lot of time rotating in the Health + Hospitals system. I'm also a health equity research fellow and I'm a member of CPHS, the Commission on the Public Health System. So, I'm here just to share a few thoughts on the impact of what hospital closures can do to communities. I think Judy will share a little bit more about kind of the historical arch of hospital closures in New York City and what the impact has been over the years. But I just want to share a few thoughts from a medical perspective and from my organizing perspective and from the health equity research perspective. So I'll start speaking about ambulance wait time and access to care. As of this fall, ambulance wait times are already at their highest in New York City since the start of the pandemic, and that includes wait times for life-threatening emergencies. Hospital closures can actually further lengthen transport time, and the increase of even only a few minutes is clinically significant. So, in life-threatening medical emergencies, as you know, every minute matters. We say in medicine, time is muscle after a heart attack, or time is brain after a stroke, because with every

minute that passes without access to treatment, more organ function is lost, and that can have catastrophic consequences to health and to life. So the assumption that patients can just go to another hospital kind of fails to recognize the many circumstances where geographic proximity really matters. Also, add the major academic hospital networks in New York City serve a much smaller percentage of Medicaid and uninsured patients in the public system. So the impacts of any closures affecting Medicaid and uninsured patients will mainly be absorbed by an already overwhelmed and underfunded public system which further impacts the quality of care of these institutions. In addition, while a hospital closure may superficially appear to reduce cost to the system, uninsured or Medicaid-- underinsured folks will still need quality healthcare and that necessitates dedicated support and funding directly to the institutions that care for them. There's ample historical data to suggest that hospital closures don't actually slow healthcare cost increases, and it's likely that closures ultimately actually increase cost to the system as displaced patients obtain care elsewhere. So thank you for the

opportunity to speak. I voice my support for the resolution at-hand and pass it over to Judy.

CHAIRPERSON NARCISSE: Thank you. And Judy Wressler.

JUDY WRESSLER: Thank you for this opportunity. I'm retired director of CPHS and a board member. And we've been fighting on this issue for over 30 years, and it just gets worse, and our fight has been around trying to save hospitals in medically underserved low-income in often communities of color, and that just makes it worse. What I have is one copy of a report that was done interviewing tenants of NYCHA houses in Chelsea that after the closing of St. Vincent's which is perhaps one of the only studies of the impact after the closing. We are a member of the Downstate Coalition, and fighting for that institution. We have maps. We did maps-- because the pictorial is really important-- that show the hospital closings have been primarily in, again, medically underserved, low-income and communities of color, and it just shows you how bad, you know, the picture is. I'm going to add one thing, and that is again, historically, the City Council at one point through the Health Committee Chair actually had a

taskforce on hospital closings. I unfortunately could not find the report anyplace, and hopefully with your help we'll be able to find it. So, I wanted to urge the Council to take an even more activist position in doing something like that so that the focus is on this because the impact on our communities is so bad. So, we have a couple of maps. I have one copy of the St. Vincent's report, and we would be very, very happy to work with you on this issue. Thank you for this opportunity.

CHAIRPERSON NARCISSE: Thank you for your time. I have a couple of questions for Greater New York. What can New York State and the City Council do to support hospitals in the City and prevent further closures?

CHATODD FLOYD: Thanks. You already took the first step this past year in supporting the resolution for increased Medicaid rates. We want to continue to see that number rise. You know, they've been paying about 30 percent less. As we scale up to get to 100 percent of the cost of care, it'll allow us to stabilize and both be able to reinvest particularly in these underserved communities. We think it's a travesty that Black and Brown people

have, you know, disproportionate access to healthcare, and that reinvestment in your support for that mission is critical.

CHAIRPERSON NARCISSE: Can you just-- you can jump in if you want to jump in when I ask question. Can you describe how the pandemic impacted hospital's financial performance? Prior to 2020, what was the fiscal landscape and how has it changed now?

CHATODD FLOYD: Yeah, so for the better part of the last 15 years, Medicaid rates have been actually pretty stagnant. So a lot of our member institutions have been losing money over-- since about 2008. However, post-- prior to the pandemic, our members have started to experience even higher rates of inflation. Since 2019, it's already been a 19 percent increase alone. You know, medical rates from over the past 15 years collectively have been around over about 50 percent compared to the CPI. This is unsustainable. We're spending far more on short-term staffing just due to sort of the workforce shortages as well as rising pharmaceutical costs and delays in insurance payments.

CHAIRPERSON NARCISSE: Tell me about delayed insurance payment. I know how delayed it can be and especially when it comes to some of our state's insurances.

CHATODD FLOYD: Yeah, exactly. So, you know, insurance both for consumers as well as for our individual facilities were sort of the victim of a lot of denials in terms of, you know, for care, and also these denials in payments. What we see is when we have to spend money to fight and reapply, that we're able to recoup about 80 percent of those funds. But what that means for smaller facilities, particularly for our safety nets where they're already operating on the margins is, those delays which can last half a year, a year or more, really impact services and can easily impact staffing. And so facilities are sort of left with the choice to unfortunately have to either make reductions in those areas, where their employment [inaudible] those services in large part due to these sort of lagging payments.

CHAIRPERSON NARCISSE: How is the delivery of healthcare changing, and the impact does

it have on the current hospital system and provision of services?

CHATODD FLOYD: What we've been seeing as of late is that there's been more a shift towards outpatient care. You know, there's been more ambulatory and other sort of facilities that are in the community, and this is sort of just response that folks may not need to be housed into traditional bed in the way that they once were, and there's other technology available for sort of shorter stents in facilities and including leveraging things like telehealth and other sort of innovations. We think that those trends will continue which is actually sort of why we want to maintain some flexibility. And you know, one of the issues of the resolution for the LICH bill is that it also extends to other service and unit reductions, and we want to just really highlight the importance for facilities to be able to be nimble to service whatever community need there may be.

CHAIRPERSON NARCISSE: Thank you. What can New York State and this City Council do to help strengthen the hospital workforce?

CHATODD FLOYD: I think first and foremost we would actually try to say we all need to collectively work together to remove restrictions in terms of the workforce. We really want to collectively work together to encourage more people to become nurses and other practitioners so that way it can ease some of the strain within facilities. We also would be remiss if we weren't to say that New York is one of the few states who were not participants of like the Interstate Medical Licensure Compact, as well as there's also additional compacts as well that we can sort of explore ways so that way we can address these critical workforce issues.

CHAIRPERSON NARCISSE: So, I want to thank you, and if my colleagues have any questions?

COUNCIL MEMBER RIVERA: In your testimony you mention that there could be good reasons for hospitals to close, and you said innovation and you mentioned some other things. I mean, that's not the case for a lot of these hospitals. Many of them are in financial constraints. So, I thought that was interesting to bring up. For these particular examples that we're sort of focused on. I know we're focused on hospital closures, but two in particular,

Downstate and Mount Sinai Beth Israel, continue to come up, but not right now, but I'd love to see some examples of when hospitals close and it was a positive thing. If you can get that information. I'm being very serious. I'd like to see that-- like, in a tangible example. So, you are against the resolution, even though it passed both the Senate and the Assembly, you all are still advocating for the Governor not to sign it, then.

CHATODD FLOYD: So, I wanted to clarify two things. One, in my testimony I do not state that a hospital closure is ever positive. We openly acknowledge that is a reduction. As a trade association, we actively want to encourage more members to both be in the community and service them. What we do say is that service units and reductions, it could be two beds, it could be four beds, it could be five bends, that flexibility allows the system to be able to continue to service needs. If you have a facility or a unit that is hemorrhaging money by miring it in bureaucracy where they are not able to say let me stave off two units, or let me be able to innovate in order to respond to community's needs. If those things have red tape of 270 days, those

things can exasperate the financial problems of the institution. We would never advocate for any sort of affirmative closure.

COUNCIL MEMBER RIVERA: Okay. Yeah, you just said the far more common motivation behind changes for the hospitals reflects-- could reflect positive developments.

CHATODD FLOYD: Yeah. And so that could be innovation. You know, dialysis as it once existed, it doesn't need to be necessarily in a fixed unit. You can allow for those machines as technology improves to be able to be mobile. So that sort of fixed bed construct is not necessarily the same, and that's one of those examples of innovation.

COUNCIL MEMBER RIVERA: Okay, I would still love examples of that, because I feel like that's an important piece of the conversation to have if there has been a right-sizing that has-- that is reflective of something positive in the community. I don't think that is discussed and I don't have that information. So, I would love to read it. And about the bill, in terms of it passing the Senate and the Assembly, but you are not in favor.

CHATODD FLOYD: So, Greater New York continues to support community engagement and so, you know, what we articulate is actually that, you know, we benefit from enhanced structure, enhanced communication both for the Department as well as with the community. They have a right to know, and the existing law, you know, as Assemblywoman Simon pointed out, only allows for community engagement on the back end. But recently as a result of department guidance from last August, there is community engagement both through the CON process and the HEIA, the Health Equity Impact Assessment, and so for those reasons we want to say that model works, but because a LICH also applies to any sort of service reduction or limitation you have to go through the approval. That approval process for department that unfortunately is not as nimble and swift as we would probably hope has the potential to exacerbate some of the financial challenges for our facilities.

COUNCIL MEMBER RIVERA: You said that it risked creating a bureaucratic bottleneck that could paralyze necessary healthcare transformation efforts, and I'm very interested in having a conversation with you all on what you think is like a positive-- like,

a step in the direction where you outlined some things you thought were right about the bill, I guess. I just want-- and I would love to have this meeting like after this where we could talk about some of your ideas on how to create transparency and accountability and your ideas for community engagement. I would love to hear that.

CHATODD FLOYD: We welcome that as well.

COUNCIL MEMBER RIVERA: Yeah, okay. And I just want to say thank you to the advocates. I wanted to ask Judy, you mentioned there was a taskforce in the past, right?

JUDY WESSLER: Right.

COUNCIL MEMBER RIVERA: Okay, if you can even find me like the term that was in, I can try to look for the report.

JUDY WESSLER: I know it was in Chris Quinn's [sic] Speakership.

COUNCIL MEMBER RIVERA: Okay.

JUDY WESSLER: And actually Helen Sears [sp?] was the Chair of that taskforce. Again, I'm not the best, but I really had a hard time. All I found was one article that referred to it which didn't very much help. But you know, perhaps the

City's archives, City Council's archives, might have something. We work very closely with that taskforce, you know, and what they were looking at and how-- and what happened. So, and I believe-- I think I'm saying this right, that one of the outcomes of that was a recommendation for the City to put in $25 million to expand primary care around, and the money was given through HHC, H+H, to take a look at that, and there was a community taskforce that came up with what to look for and how to look for it, and-- you know, and what communities to target. So, there was-- there were other outcomes of that, but that was one of the positive outcomes as I remember. And if I may say just one more thing? It was not until just a couple of years ago that Greater New York Hospital Association did anything about safety-net hospitals. They finally-- when Laray Brown [sp?] was the president, set up a taskforce or some kind of committee to look at the safety-net hospitals, and that was very late in the game. So, I'm glad to hear that, you know, they're concerned about this, but I would be concerned about their unwillingness to support this bill and you know, the need for the community to be involved. It's only through the

community involvement and with Council and other elected officials that we've been able to accomplish anything. So thank you for this question and [inaudible].

COUNCIL MEMBER RIVERA: Thank you, and thank you very much.

CHAIRPERSON NARCISSE: Thank you, and thank you for being here, and we appreciate you taking time out to come to testify. Thank you. Thank you everyone. The next panel is Andrea Gordillo, Jesus Perez, Linda Charles, Jose Gonzalez, and Mark Rubin. Andrea Gordillo, Jesus Perez, Linda Charles, Jose Gonzalez, and Mark Rubin.

ANDREA GORDILLO: Hi, good afternoon Chair Narcisse, members of the Committee. Thanks for having us today. My name is Andrea Gordillo and I'm the Chairperson of Manhattan's Community Board Three. I'm here to testify in expressing our opposition to the proposed closure of Mount Sinai Beth Israel Hospital on East 16th Street, and furthermore, the importance of local input on closures and changes to healthcare access. 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 our board earlier this year, which we've submitted to your records, the closure of Mount Sinai Beth Israel would have a significant negative impact on our district which represents the East village, Lower East Side and Chinatown. The hospital serves as a large portion of Manhattan Community District Three including residents who face economic challenges and rely heavily on the services provided. Twenty-seven percent of our residents in our community district live below the poverty level, and 23 percent of the residents are over 65; 44 percent of seniors are below the poverty level. The loss of the hospital would exacerbate existing healthcare disparities leaving many individuals without access to necessary medical care. A local coalition, many of whom are here today, conducted and independent Health Equity Impact Assessment to analyze the potential consequences of the closure. Preliminary results indicate that emergency medical care as we all know is the most utilized service at Mount Sinai Beth Israel followed by surgery, testing, and cardiac care. The proposed closure would force patients to travel long distances to access these services

creating barriers for those who cannot afford private transportation. The local input was devised without proper or sufficient support from government or agencies. Furthermore, the closure of Mount Sinai Beth Israel would have a detrimental impact on our community's ability to respond to emergencies. Community Board Three urges the New York City Council to oppose the closure of Mount Sinai Beth Israel, and as a Community Board we underscore the critical role, local input and lived experiences that can inform changes to healthcare services. Mount Sinai, it's a vital institution that provides essential healthcare services to our community and plays a critical role in addressing healthcare disparities and we deserve-- we believe it's essential to preserve it as a cornerstone of our healthcare system. Thank you.

CHAIRPERSON NARCISSE: Thank you. Jesus Perez?

JESUS PEREZ: Thank you. Good afternoon, Chairwoman Narcisse, Council Member Rivera. Thank you for the opportunity to testify before you today. My name is Jesus Perez. I am the District Manager of Manhattan Community Board Six. Manhattan Community Board Six strongly believes that the New York State

Department of Health acted very hastily and irresponsibly in their decision to approve the closure of Mount Sinai Beth Israel Hospital, and does not address the issues raised by our community. State Department of Health did not fully consider the impact that approving the closure of Mount Sinai Beth Israel would have on our neighbors and the district. The hospital 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 wellbeing 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 significant across all categories, including EMS for life-threating situations. The heavy traffic conditions in Manhattan Community District Six emphasize the criticial importance of keeping MSBI open. As swift access to 24-hour emergency room care is vital in cases involving cardiac or stroke patients where delays in transportations could lead to preventable loss of life. This decision is not-- 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 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 their care. The decision by the New York State Department of Health will have devastating consequences to our community, particularly those with chronic conditions who require regular and immediate medical attention. Thank you very much for your attention.

CHAIRPERSON NARCISSE: Thank you. Now we hear from Linda Charles.

LINDA CHARLES: Good afternoon. My name is Linda Charles. I'm a nurse of 34 years in New York City, 30 years I have worked at Mount Sinai Beth Israel hospital. Discussing accessibility for downtown Manhattan, I've watched numerous hospitals close in this area. When we discuss life is brain, and having a heart attack. We discuss how quickly we can get to an emergency room which Mount Sinai BI actually affects everybody in this room, because if

somebody was to have a stroke or a heart attack here, we are one of the closest STEMY [sic] and stroke centers to even downtown Manhattan. Whereas people come in here to come to work from other states, other areas. They deserve healthcare in their area, plus the people that live in the community. Besides working at Beth Israel, I also live on the Lower East Side, so I've seen what this had done to my family, my community and my neighbors. We discuss urgent cares open. As you see, there's an urgent care basically on every corner you walk by. I work in the emergency room, and the constant remark from everybody is, "Hi, I was just sent here by urgent care. I was just sent here by city MD." So, we're obviously doing something wrong because it's causing people to pay for urgent care and then pay for an ER visit. With that said, I know earlier a question was asked how Bellevue will staff to deal with the closure. I had a colleague go and interview last week at Bellevue for a job. He was told by the recruitment that they need to double their staff in order to accommodate what will happen downtown. With that said, they're already short-staffed and my colleague did turn down the job there. We will also

be losing psychiatric emergency room at mount Sinai Beth Israel. Behavioral health is a huge issue and losing a 10-bed psychiatric emergency room will be definite detrimental. Bellevue goes on diversion very, very frequently. We fill it at Beth Israel when that does happen and our ER fills up. So when Bellevue fills up now, there will be no diversion for that. Thank you.

CHAIRPERSON NARCISSE: Thank you. Now, we'll hear from Jose Gonzalez.

JOSE GONZALEZ: good afternoon members of the City Council. Thank you for the opportunity to speak here today about this important issues. I'm here with some of my colleagues from Mount Sinai Beth Israel. My name is Jose Antonio Gonzalez. I'm a member of 1199 SEIU and have been an employee at the hospital Beth Israel for over 35 years. Currently, I work in the corporate office, but I've held many titles and different hats throughout the years, including during the COVID-19 pandemic when I was deployed to the front lines working in materials management, ensuring that we were addressing the needs of the community Beth Israel serves and providing the necessary care that carried us through

this strenuous time. I'm not only here testifying a s a member of 1199 SEIU or as an employee, but also as a member in the district and in the community that the hospital has served. I was born and raised in Chelsea. St. Vincent's, that's gone. I visited Cabrini Hospital. That's gone. And now Mount Sinai Beth Israel. That will soon be gone. My in-laws work there. It was a family hospital. Both my daughters were born there. My father sadly died there in the hospice room. Hospitals are the cornerstone of our communities. Hospitals complement and amplify the efforts of other parts of the health system. The hospitals in this city provide continuous availability of services for maternal, emergency, and complex health conditions. Our safety-nets often function as some people's main form of primary care. Beyond providing direct care, hospitals also are a significant player in the local economics and 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, illnesses and chronic disease have continued, including the aging of many populations, the aging population that's

growing for the demand for care. The possibility of a closure for Mount Sinai Beth Israel has been up in the air for many years, a sad reality for many hospitals. Prior to the COVID pandemic financial pressures on many hospitals and healthcare facilities require them to downsize, merge or close, but following the aftermath of the pandemic, even more facilities have been unable to sustain themselves. Hospitals matter to the community, often marking central points in our lives. They're also a fundamental part of our health systems as an instrument for care coordination and delivery. We need to take time to explore initiatives that will effectively keep hospitals open, retain workers, and increase resources for providing care. Thank you so much. We also must also fully fund New York's Medicaid program to stabilize safety-net hospitals and reduce healthcare disparities in our communities. Thank you once again.

CHAIRPERSON NARCISSE: Thank you. The next is Mark Rubin.

MARK RUBIN: Good afternoon. My name's Mark Rubin, and I'm a nurse at Mount Sinai Beth Israel. I work in the Intensive Care Unit. Want to

thank the Council for having these hearings. It's a critical issue right now in the City and I appreciate that. I have worked at the hospital for 13 years, as I said, and it's not only where I work, I also live in the West Village, and since St. Vincent's is closed this has become the West Village's also local hospital. I live in a building that is a-- considered a naturally-occurring retirement community. It's West Bath [sic]. I'm sure you all know it. I used to be a photographer before I became a nurse. And all the people in my building depend on Beth Israel for their services since St. Vincent's is closed, and myself included. And hospitals across the City continue to close and we continue to lose services, and for all the talk of urgent care, there's not one of my patients in the ICU who could be treated in an urgent care setting. Hospitals are necessary. They can't go away. As much as the medical establishment would like to move things to a cheaper, easier situation, hospitals will never not be needed, and this attack on our hospitals in New York City has to stop, and the loss of Beth Israel will be devastating to the entire community from 33rd Street down to the

tip of Manhattan, and I urge the Council to do everything they can to stop the closing. Thank you.

CHAIRPERSON NARCISSE: Thank you, and thank you for committed to fight for healthcare equity in our city. Thank you.

CHAIRPERSON SCHULMAN: Alright, I'm going to take over for Chair Narcisse for a little bit. So I'm going to call the next panel. Charles My, Amelia Wagner, Stephanie Heyman Reckler, Axia Torres, and Renee Kinsella. Okay, I'm going to call Charles My one more time. Okay, I guess they might have left. Alright, so Amelia Wagner?

AMELIA WAGNER: HI there.

CHAIRPERSON SCHULMAN: Hi.

AMELIA WAGNER: Thank you to the Committees on Health and Hospitals for this opportunity to speak. I'm here on behalf of the Community Service Society of New York, an organization with 180-year-old history of advocating for more equitable New York, especially for low and moderate income communities. Thanks to the Council's support, CSS coordinates the Managed Care Consumer Assistance Program, or MCCAP, which has helped over 16,000 city residents navigate the complex healthcare

system. We work with 12 community-based organizations across all five boroughs, reaching the communities that need it most. MCCAP has been especially critical as the healthcare roles and hospital resources have shifted drastically since the start of the pandemic. We're here today because of the profound impact of hospital closures on New York's most vulnerable communities. Since 1996, over 50 hospitals have closed statewide with a third of these closures in New York City alone. National research consistently shows the hospital closures reduce access to care, increase patient mortality and hurt local economies, especially in low-income and racially diverse neighborhoods. In June 2020, CSS issued a report on how structural inequalities in New York's healthcare system exacerbated health disparities during the COVID-19 pandemic. In the earliest days of the pandemic when patients relied on hospital-based care, Black New Yorkers had four times the COVID-19 mortality rate compared to white New Yorkers. The report linked the location of hospital closures to exacerbated health disparities at the height of the pandemic. A clear example is Queens where the closure of four safety-net hospitals left

Elmhurst Hospital alone to serve on the nation's COVID-19 hotspots. To protect New Yorkers, we urge the Council to support the resolutions to keep Beth Israel open in lower Manhattan and to call on the Governor to sign the Local Input in Community Healthcare Act. This legislation would mandate public input when hospitals or key units close, ensuring that communities play a role in crucial healthcare decisions. Time is of the essence. The Governor must sign this bill by the end of the year. Thank you for your time and consideration.

CHAIRPERSON SCHULMAN: Thank you very much. Stephanie Heyman Reckler.

STEPHANIE HEYMAN RECKLER: Yes, thank you Chairs Narcisse and Schulman for the opportunity to present some comments today. I am Stephanie Heyman Reckler. I am 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 eastside all my life. We are fortunate to have six major hospitals close by. As you have heard the testimony at the press

conference from Lois Uttley, we have more than 10 hospital beds for every thousand residents. That is more than four times the citywide rate. Yet, it is in our neighborhood that Northwell Health System is proposing a $1.6 billion expansion plan for Lenox Hill Hospital. There are many personal reasons why I and my neighbors do not want this Lenox Hill expansion, 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 the city do not have enough hospital beds to meet their needs. The Lower Eastside, for example, does not have enough hospital beds as it is now, and the residents are in serious danger of losing Beth Israel hospital medical center. 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 need most them and discourage huge hospital expansion in already well-served neighborhoods like Lenox Hill. And I appreciate the privilege to present to you today.

CHAIRPERSON SCHULMAN: Thank you very much. Axia Torres?

AXIA TORRES: Can you hear me?

CHAIRPERSON SCHULMAN: Yes.

AXIA TORRES: Good afternoon to the entire Council Committee, the Chairwomen, Councilwoman Rivera. I-- my name is Axia Torres and I am the Chairperson for the Manhattan south district council of Presidents for NYCHA, for the developments of all NYCHA from 105th Street all the way to Alfred E. Smith House of which I am the President Resident Association. I am here today because the most impacted people are going to be people in public housing of color. We once more time are being totally, totally disallowed. This happened to us during ERAP. We had to go fight to get money when everybody else is getting it, and so this is constant. But I just want to share a personal note of what will happen, and I know Councilwoman Rivera knows this because on February 1st, 2024 of this year I experienced what the closing of Beth Israel means to our community on a personal level. My Ti-Ti [sic] was sent to Bellevue and her hospital is Beth Israel, because she had a trauma, and they moved her to

Bellevue, and I am not-- so we're all clear-- criticizing the healthcare that she got in Bellevue. It was great. However, the transferring her to Bellevue was horrible, because Bellevue did not have the capacity in terms of personnel, and the overflow in that emergency room actually put all of those patients in danger. At which point, I called the Councilwoman to say who chairs this committee, because for the community, because this is not acceptable. By the end of the day, even the Governor knew who my aunt was, but that's not the point. Not every-- and I know I'm over the time, but not every Ti-Ti has a niece named Axia who can advocate like that, and I just want to-- in closing, I had a resident that I bumped into and I had to intervene, and her husband did die that day, right? And he would have died alone had I not interfered because Bellevue could not allow any visitors in the emergency room, because people-- there was no space to walk in, including the medical staff. And so the closing of Beth Israel cannot be done, and I urge everyone on the Council whether you live in the lower east side, up the upper side, I don't care where you live you need to-- we need to unite and we need to

tell the state that they cannot close our hospital. And I thank you.

CHAIRPERSON SCHULMAN: Okay, thank you. Renee Kinsella?

RENEE KINSELLA: Thank you for the opportunity to speak today. My name is Renee Kinsella and I'm a long-time resident who raised three children on the East side of Manhattan. I very much oppose the closure of Mount Sinai Beth Israel. Beth Israel has been a cornerstone of the community ever since I can remember. I had my three children there and most of my friends had their kids at Beth Israel, too. It then became the place we brought our kids with scrapes and breaks, and where many of us as we've gotten older have had surgery or inpatient care. Last September I woke up in the middle of the night thinking I had food poisoning. Turned out to be an obstructed bowel which causes a lot of pain. Practically delirious, I went to the Beth Israel emergency room for help and I received excellent care, both in the ER and then as an inpatient for several days. My intake and move to the hospital was seamless. My understanding, though, is that last week the emergency room at Bellevue had over 70

people in the emergency department waiting for a bed. This is why Beth Israel is still open. If the City of Yes for housing is approved, it'll no doubt create even more units and bring more people to the neighborhood, and I'm concerned that people, my neighbors, myself and friends will be unable to access care in a timely way if at all if this and other hospitals close. Our award-winning Beth Israel hospital that had always been a wonderful and accessible place to obtain care and every specialty area has been dissembled by Mount Sinai department by department. Hospital administrators told us that they would not fund our local Mount Sinai Beth Israel hospital and instead told us they'd create centers of excellence at their other exiting hospitals so as to better serve us, the local community, without ever discussing with us or our legislators what we might actually want or need. Hospital administrators alone have made the decisions regarding Beth Israel that would determine how and if our community can access care. I believe that this issue is one everyone should have the opportunity to weigh in on given that people's lives may be at stake which is why I hope that this council will support Council Member

Rivera's resolutions to stop the closure of our hospital and ensure that the community and our local government has a voice in these closure discussions. Thank you.

CHAIRPERSON SCHULMAN: I want to thank this panel. Thank you very much. We really appreciate what you have to say. So, you know, we appreciate it. Thank you.

CHAIRPERSON SCHULMAN: I want to call up Charline Ogbeni, Mbacke Thiam, Karen Flemming, and Jean Ryan. So, you're Charline? Okay, hold on one second. I want to see if we have-- we're missing one, two-- we're missing one person. Are they not here? Alright, the other thing, I just want to remind people we have a lot of people left to testify, so if you could keep it please to two minutes. You can certainly submit your testimony, a full testimony if you want to. You have 72 hours to do that. So, we appreciate that. So, who-- I'm sorry, you are? Okay, so one second. You go first, go ahead.

MBACKE THIAM: Hello everyone. Thank you, Council Member Schulman and Council Member Rivera, also Council Member Narcisse for having us

and being able to hear from the committee. My name is Mbacke Thiam. I'm the Housing and House Committee Organizer at Center for Independence of the Disabled. We advocate for people with disabilities in the five boroughs of New York City. And also we are in Queens and Manhattan. I wanted just to shed light on what you were saying earlier which is the health equity impact assessment which was not done and was-- and the people with disability was not included. So it was done-- it was done so you are not included. So, it's something that's very impactful for people with disabilities to just close Beth Israel. And I would take the example of one of our consumer. His name is Dustin Jones [sp?] who would [inaudible] maybe a couple of minutes of walk or wheel to get to Beth Israel, now may span an hour or more before getting the care that he needs at Brooklyn. Depending also of his care. I'm sorry. His primary care service. So however-- because of that I just want to shed light that we are here to advocate and also we just approve the DOH for approving-- allowing Beth Israel to close. So this was decided on July 26th which marked the 31st anniversary of American with Disabilities Act, adding insult or injury to people

with disabilities. Also, I wanted to share that CIDNY as a member of the Save Beth Israel and NI [sic] Coalition, we will keep fighting and believing that we can help Beth Israel open and fully operate since we work with the state legislators and Assembly Members to pass Local Input in Community healthcare Act which also we are urging the Governor to sign that legislation. Yes, and I'm also saying that we are here to support the Resolution 0222024, Resolution 0232024, and Resolution 03339 CIDNY-- we will submit our written testimony but we're here to--

CHAIRPERSON SCHULMAN: [interposing] Okay.

MBACKE THIAM: advocate for people with disability and trying to do our best to keep Beth Israel open.

CHAIRPERSON SCHULMAN: Thank you very much. Just so everybody knows, I'm a co-sponsor of the resolution. So I just want you to be aware. So, Chirline-- Charline, I'm sorry.

CHARLINE OGBENI: Good afternoon. My name is Charline Ogbeni and I thank you for the opportunity to testify here today. I represent Supporting our Mothers Initiative, a cradle to college company that provides parenting support and

resources to families across New York. We provide full-spectrum doula service and lactation services to families. In 2009, a baby girl was born on the B61 bus. In 2017, a MTA subway cleaner assisted a baby born on the four, five, and six Brooklyn Bridge stop. In 2023, a baby was born on the Jackie Robinson Parkway, and just this week, a baby was born on the I990 upstate in Niagara City. The list of out-of-hospital births goes on and on, and these stories often capture attention and make news, but there is seldom any news or recognition for births that happen at birth centers. Currently, there is only one birth center in New York City, despite the fact that over 100,000 babies are born each year here in the City. The majority of these births are vaginal and don't require hospital admission which means many families could benefit from the option of birthing at a birth center. With the impending potential hospital closure, we want to offer this as a solution to help triage low-risk maternity needs as the remaining hospitals have to grapple with the overwhelming needs but minimal resources. One of the barriers holding back the expansion of birth centers in New York State is the Certificate of need requirement. We are

advocating for the adoption of deem [sic] status for CABC accredited facilities replacing the current licensure process. Birth centers offer a unique and valuable approach to childbirth providing an environment that is supportive, safe, and comfortable. It also is cost-effective when compared to traditional hospitalization for the same individual. Additionally, I want to propose the committee's support for establishing the first BIPOC-led doing a milk bank in the city, in New York City. An investment in donor breast milk is an investment in our future citizens and reduces the long-term cost of future health disparities experienced by our most vulnerable populations. Thank you.

CHAIRPERSON SCHULMAN: Thank you. And you are-- I'm sorry. Jean [sic] Okay, great. Go ahead.

JEAN RYAN: Hi, good afternoon. I'm Jean Ryan, President of Disabled in Action of Metropolitan New York, otherwise known as DIA. 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've been through two hospital closure,

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 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. He moved to an inaccessible office with a step and a very narrow door I couldn't fit through, and I had to try to find some other doctor, and actually I've never been successful. 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 a 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 and that's really important if a hospital does close. And then I wanted to say that I was shocked when I recently went to the City MD and they had x-ray machines but no

techs. She said none of them had techs, and they might get one in two days for a few hours. That was like-- well, how could you then go to urgent care? The last thing I wanted to say is that I also worry about hospitals closing, because when the next epidemic comes to New York City, where will we go? Thank you.

CHAIRPERSON SCHULMAN: Thank you very much. And to your point, City MD is not the answer for this. The answer is for us to have the hospitals that we need and the care that we need where we are and by the way, you know, City MD in addition, you know, they have a pay structure that doesn't help people who have little means, so.

JEAN RYAN: Yeah, and apparently they don't have a pay structure that helps the employees either. So, yeah. I don't see urgent care places as substitutes for hospitals.

CHAIRPERSON SCHULMAN: They're not. They're not.

JEAN RYAN: But if we're being told to go there--

CHAIRPERSON SCHULMAN: [interposing] Right.

JEAN RYAN: I just want to say no, it's not the same.

CHAIRPERSON SCHULMAN: No, I agree. Alright, thank-- I want to thank this panel. Thank you, Jean. Thank you everybody. Appreciate it. I'm going to call up the next panel. Deborah Socolar, Mark Hannay, Lois Uttley, and Sommer Omar. Okay, Deborah Socolar? Go ahead.

DEBORAH SOCOLAR: I have a vocal cord disability, I hope you can understand me okay.

CHAIRPERSON SCHULMAN: Sure.

DEBORAH SOCOLAR: Thank you very much for taking up this vital topic of this hearing. My name is Deborah Socolar. I live in upper Manhattan. I am both a researcher on healthcare access and costs and an access advocate for years at Boston University and now independently. I'm speaking today only for myself. I hope the council will urge the Governor to sign the LICH bill and will also support Senator Kristin Gonzalez bill on at-risk hospitals. Here are a few brief points that I'll expand on in testimony that I'll email. Two lessons from the pandemic: we need more single-bed hospital rooms to reduce airborne infections, and we need surge capacity. So

let's assume that all existing hospital capacity is needed until proven otherwise, truly proven otherwise. When a hospital closes, evidence suggests that as many as a third of patients completely lost to the healthcare system, not finding their way to other care. Appallingly, when New York's officials approved closing Kings Brook, they explicitly assumed that a substantial share of its inpatient volume will not materialize at other hospitals. This should not be acceptable. Closing Kings Brook was supposed to be fine with two other hospitals very nearby, but right now far from the crunch of flu season, Downstate and Kings County, you're running with only one percent of their non-ICU beds [inaudible]. Let me just mention very quickly. Research on urban hospitals, my colleague Alan Seger [sp?] shows that for decades, the single strongest predictor of which hospitals would close is the percentage Black in the community. And finally, since a Boston hospital in my old neighborhood closed two months ago, local community health centers not only have more patients to see, but they have more complex, sicker patients to see. So, that is delaying care for everybody. I really appreciate hearing that the City is-- the City

Council Committees here are contemplating promoting the idea of city health planning. And thank you very much.

CHAIRPERSON SCHULMAN: Thank you so much. Mark Hannay?

MARK HANNAY: Good afternoon. I'm Mark Hannay. I'm Director of Metro New York Healthcare for All. We're a regional community labor coalition that works on healthcare issues, and one of our projects is to coordinate the Save Beth Israel and New York Eye and Ear Campaign. Thanks for holding this hearing. It's long overdue and really important. All hospitals in New York State are licensed as charitable institutions to serve their local communities and larger regions, and it's the obligation of hospital operators to figure out how to do that in partnership with state and local governments and local community stakeholders. We and all the various local communities across our city deeply value our local hospitals, and they're among the most important and necessary community institutions. While the responsibility of hospital industry oversight historically falls under the purview of state government, in the eyes of many of

us advocates, our state leaders have abdicated that responsibility and obligation to represent the public's interest and instead of ceded the matter to industry and private market forces. So, unfortunately, for better or worse it falls to our local governments to step into this breach as best you can, and we urge you to seize that opportunity and be creative and bold. We have some ideas for you to consider. My written testimony goes into that further. Yes, absolutely urge governor Hochul to sign the Local Input for Community Healthcare Act. Secondly, have the New York City Department of Health comment on all full-review certificate of need applications submitted by hospitals to the New York State Department of Health. Three, create and revive or revive a regional health system agency for New York City to undertake ongoing regional health planning for New York City. And finally, require all individual hospitals to have an active community advisory board comprised of a variety stakeholders from the local community. We must take on this issue of hospital-- access to hospital care equity across our city. We cannot continue to concentrate hospital services on the upper east side of Manhattan, and

they must be available in all our communities across the City.

CHAIRPERSON SCHULMAN: Thank you very much. Lois Uttley?

LOIS UTTLEY: Good afternoon. I'm Lois Uttley. I've been working with community coalitions across New York and really the nation for more than 30 years to try to protect their access to crucial hospital services. So, I want to warn today that really hospital closings are worsening already dangerous inequities in access to hospital care across our city. Medically-underserved New Yorkers-- I mean people who are disabled, frail elderly, people with low incomes, pregnant people, they're losing their trusted local hospitals. They're facing long and exhausting trips to other unfamiliar hospitals through congestive traffic. Will they get there in time if it's an emergency? Will they have to wait for hours because of overcrowding? Will there be a bed available if they're going to be admitted? I think that's seriously in doubt. As you know, Chairperson Schulman, Queens which lost four safety-net hospitals over the last 20 years now has the lowest number of hospital beds per thousand people of

any borough, 1.65, and the second lowest is Brooklyn, as I'm sure Assemblywoman Narcisse is well aware. Danger of losing SUNY Downstate has only two hospital beds for every thousand people. Manhattan where we're sitting by contrast has 5.7 hospital beds for every thousand people. That's more than twice the citywide average of 2.7. But even here in this borough, there are stark disparities in access to hospital care. The affluent upper east side has 10.5 hospital beds per thousand people. That's more than four times the citywide average. By contrast, a much poorer and more diverse lower east side has less than one hospital bed per thousand people. Yet, the lower east side is in danger of losing its hospital while the upper east side is slated for a huge hospital expansion at Lenox Hill. So we need policy makers at the state and city levels like you to take action to ensure that hospital capacity is properly distributed where it is needed, not only in the communities that are richer, whiter, and have commercial health insurance. We need equity in hospital care. Thank you.

CHAIRPERSON SCHULMAN: Thank you. Sommer?

SOMMER OMAR: Good afternoon. My name is Sommer Omar. I'm one of the attorneys representing community plaintiffs in the ongoing lawsuit to keep Mount Sinai Beth Israel hospital open. We have been arguing since we first filed our papers in February that the Department of Health should not have approved Beth Israel's closure because the remaining hospital is located nearby, specifically Bellevue and NYU Langone, simply do not have the capacity to properly care for patients that would have ordinarily gone to Beth Israel, especially emergency patients. According to the Department of Health's own guidelines, the hospital that is shutting down has to ensure that surrounding area hospitals have the capacity to absorb those surplus patients. That is simply not the case here. Current occupancy data shows that both Bellevue and NYU Langone are already over capacity. According to the Department of Health's own data, Bellevue's average occupancy was 108 percent in April 2024. NYU's average occupancy was 157 percent in April 2024. What's alarming is that this data is in the State Department of Health possession, yet there is no credible plan in their won administrative record for either one of these

facilities to be able to suddenly expand their physical infrastructure staffing capacity and resources to be able to absorb the more than 60,000 patients how visit Beth Israel's emergency department annually. This will lead to a grim domino effect that others have already testified to where patients will experience longer wait times, worse care, or will be diverted to hospitals even further away while they're in the midst of an emergency. After St. Vincent's Hospital closed in 2010, lower Manhattan was told not to worry, because we'd still have Beth Israel to the east. And analysis following the closure of St. Vincent's found that patients did shift to Beth Israel for emergency care. If Beth Israel closes without an alternative hospital to go to, hundreds of thousands of people who live in, work in, or simply happen to be downtown during a healthcare emergency will be left asking, "Well, now what?" This is just not tenable, and this community has been fighting tooth and nail for a year to find another solution. I urge you to both call on Mount Sinai to stay open or to come to the table and work with the community to find a way forward that doesn't

wreak havoc in lower Manhattan. Thank you for your time.

CHAIRPERSON SCHULMAN: Thank you. I want to thank this panel very much for your dedication and advocacy for our healthcare. Thank you. The next panel is Redetha Abrahams-Nichols, Kimberly Murdaugh, and David Siffert. You're Kimberly or you're Redetha?

KIMBERLY MURDAUGH: Hi, my name's Kimberly Murdaugh.

CHAIRPERSON SCHULMAN: I'm sorry?

KIMBERLY MURDAUGH: I'm Kimberly.

CHAIRPERSON SCHULMAN: Oh, you're Kimberly. Wait one second. Is Redetha or David here? No, okay. Go ahead Kimberly.

KIMBERLY MURDAUGH: Hi, my name's doctor Kimberly Murdaugh and I'm a physician living in the lower east side, and I'm also part of the Save Beth Israel and New York Eye and Ear Campaign. Thank you everyone for having me today. Our campaign stands ready to work with both the Council and others to address the crisis of inequitable hospital closures in New York. I wouldn't be in New York today if it weren't for Beth Israel Hospital. Both of my parents

are from North Carolina and they grew up in the Jim Crow south going to all-black segregated schools. Against all odds, I got to go to Harvard University and Yale School of Medicine, and during my time at Yale I learned about a historic hospital in New York City that had served lower Manhattan for over 100 years. According to the publicly available Mount Sinai Library archives, Beth Israel was founded to take care of Jewish immigrants living on the lower east side who had been turned away from city hospitals because they were overcrowded. Mount Sinai Beth Israel was a pioneer in many techniques including colonoscopy. It was the first hospital to recognize AIDS as a clinical entity, and it developed some of the first AIDS medication in clinical trials. So when I learned all of this as a medical student in 2017, I knew that I had to train at this legendary hospital, and I received a world-class education that I possibly might not have gotten from Harvard or Yale, but my internship was very tough. Mount Sinai was understaffed. We had already suffered of the closure of St. Vincent's Hospital, and at times it felt like Beth Israel was holding the community together. That was already seven years ago and since

then our population has grown. Our seniors are older. We've suffered a pandemic, and I know that this closure would devastate our community, and what happens next in the fight to save Beth Israel is going to set an example not only to New York but to the world of what New Yorkers stand for. Thank you for your time.

CHAIRPERSON SCHULMAN: Thank you very much. Really appreciate it and appreciate the story that you told.

CHAIRPERSON NARCISSE: To take your time as a practitioner to come in, we appreciate that even. Thank you so much.

KIMBERLY MURDAUGH: Thank you so much. You're also saving lives.

CHAIRPERSON SCHULMAN: Is it Bruce? I'm sorry, Bruce Rosen? Okay, go ahead.

BRUCE ROSEN: Is this on?

CHAIRPERSON SCHULMAN: You have two minutes.

BRUCE ROSEN: Okay. I actually spoke last week at the City of Yes, and it seems like a continuation, because it was a lot of effort for very little housing with no support that would include

hospitals. Once City Planning had a capital program which would have included that, it doesn't have that. All 59 Community Boards require to have at least general hospital. That no longer exists. Case in point, Queens 12, Jamaica, Hollis, St. [inaudible], Rochdale [sic], quarter of a million people. That's where Mary Immaculate was. It was part of the failed St. Vincent's Catholic over there. Queens doesn't have a medical school. It is the largest jurisdiction in the country without one. There are 14 states in the District of Columbia that have. The area of southern Queens has three-quarters of a million people, and there are only two hospitals. I don't think that there's a top 20 city in the country that has just two hospitals. But to those hospitals on there, Beth Israel opened a state-of-the-art ER just 13 years ago. I had been in that ER when it was brand new and what proceeded it which was [inaudible]. So, yes, old buildings can have new facilities. I was also in New York Eye and Ear for my first cataract operation. Old building but state-of-the-art facility for [inaudible]. And my subsequent one which was in an outpatient facility, a beautiful [inaudible] but not as good as that. the

other thing that's happening, because real estate is pulling this and real estate is pulling this because in Manhattan you have medical tourism is you're getting things like replacement for housing and whatnot over there.

CHAIRPERSON SCHULMAN: You need to wrap it up, so.

BRUCE ROSEN: Okay. What I would say is basically as you've heard, you're going to have backlogs. I have seen because I have been in Mount Sinai's main ER four times in the past year and a half. It gets very crowded. My brother was recently in Weill Cornell. I couldn't even visit him there because they had so many people while he was there. So, this is what you're faced with.

CHAIRPERSON SCHULMAN: Okay.

BRUCE ROSEN: And I think that you should be doing everything to push back. Thank you very much.

CHAIRPERSON SCHULMAN: Okay. Thank you so much. Appreciate it.

CHAIRPERSON NARCISSE: Thank you all of you came especially here to share your thoughts and experiences today. If there is anyone in the Chamber

who wishes to speak but has not yet had the opportunity to do so, please raise your hand and fill out the appearance card with the Sergeant at Arms at the back of the room. Seeing no hands in the Chamber, we'll now shift to the Zoom testimony. When your name is called, please wait until a member of our team unmutes you and the Sergeant at Arms indicates that you may begin. We'll start with Doctor Danielle Greene followed by Jeannine Kiely.

SERGEANT AT ARMS: You may begin.

DANIELLE GREENE: Thank you so much for inviting me here today Chairpersons Narcisse and Schulman and the members of the Committee on Hospitals and the Committee on Health. I am Doctor Danielle Greene, Doctor of Public Health, not medicine, and Executive Director of State and Local Public Health Initiatives at the CUNY Graduate School of Public Health and Health Policy. And I agree with many of the points that have already been made today, I think it is really important that we focus on the needs of Black and Brown and underserved communities, and that we address longstanding gaps in care and inequity and that we need to support our safety-net hospitals. I was going to begin by talking about the

data analysis that we were asked to do by Senator Kruger's office this summer which I believe you already have a copy of. A lot of the data's already been discussed. It's late in the day so I'm going to skip to sort of my thoughts on the overall process, and you can see the data in our written testimony that we'll submit in the next two days. I wanted to say that I think as we talk about this, we need to adjust our framework, because there are many services now that hospitals provide that people are getting outside of the building and that we typically think of as a hospital, and there are many things that we are now asking hospitals to do like social needs assessment that they didn't used to do. At the same time, there are many reasons why people go to a hospital and why they choose which hospital to go to, including reputation and cultural humility, and there are-- and those may not always be in their neighborhood. Therefore, I think we need to be asking new questions.

SERGEANT AT ARMS: Thank you. Your time expired.

DANIELLE GREENE: [inaudible] I'm sorry. One last thing. There is no gold standard for the

bed ratio. WE looked at this. There's a lot of comparisons between communities about the haves and the have nots, but there is no gold standard, and it is very important we look at having continuums of care within all of our neighborhoods and looking at what neighborhoods need. I support the regional planning--

CHAIRPERSON NARCISSE: [interposing] Can you wrap it up for us, please. Time is up. Okay, but I have question for you before you go.

DANIELLE GREENE: Oh, okay [inaudible].

CHAIRPERSON NARCISSE: Okay, Hospital and Health Committee staff received your analysis on hospital data based on the borough and hospitals, right. This was a tremendous resource, and we are grateful to you and your team for putting this together. In the future, what type of data metrics would be the most helpful for you and your team to have access to? How would this impact the work that you do at CUNY?

DANIELLE GREENE: We use data from open access data that looked at the beds based on the certificate of occupancy that was given when the hospitals [inaudible] opened, and that's where the

unit's data is, and then we also looked at staffed beds, which as you may know is the bed that can actually can be used, because you have the nurses, the doctors, the cleaning facilities, all the supportive services to actually put a patient in that bed. That bed, that staff bed data was not available by unit. So, we would really love to have that data because that's the beds that are actually getting used, not the beds that were promised.

CHAIRPERSON NARCISSE: Thank you. As a constituent and researcher on public health, what type of risk do you foresee for the community in the event that Mount Sinai and Beth Israel, Mount Sinai Eye and Ear, or SUNY Downstate Medical Center are closed?

DANIELLE GREENE: That's a big question. I think that as people have said, the concern is about emergency care. I think that-- the reason why I think these analogies are inadequate is because we're also not looking at what else in the neighborhood or could be in the neighborhood. There's been-- I just was at the Maternal Mortality Legislative Breakfast last week, and there were conversations about the need for more birthing

centers and why maybe hospitals aren't the best solution. So I think it's not just looking at what happens when the hospital closes, but what else is in the community or could be in the community at the same time. So it shouldn't just be oh, a hospital's closing, everyone's moving to the next hospital, which would be disastrous. It's what else can we do to sustain a community and make them healthy. Can we invest in prevention and primary care as well?

CHAIRPERSON NARCISSE: Would you say that-- the saying that I always put out there, it's better for preventive than curing, because it's cost-effective. So I thank you.

DANIELLE GREENE: Well, yeah.

CHAIRPERSON NARCISSE: thank you so much.

DANIELLE GREENE: Absolutely.

CHAIRPERSON NARCISSE: Thank you so much for your time.

DANIELLE GREENE: Thank you.

CHAIRPERSON NARCISSE: Jeannine Kiely?

SERGEANT AT ARMS: You may begin.

CHAIRPERSON NARCISSE: Followed by Mario Henry.

SERGEANT AT ARMS: You may begin.

JEANNINE KIELY: Hi, good afternoon. I'm Jeannine Kiely, a member of the Coalition to Save Beth Israel, New York Eye and Ear. I'm also Democratic District Leader downtown and a former investment banker to the not-for-profit healthcare systems. I urge you to pass the resolution calling on Governor Hochul to sign the LICH Act. If this were in place, decisions would include the failure of Mount Sinai's management and how it systematically dismantled Beth Israel Medical Center, all likely motivated by lucrative real estate values and ignoring the healthcare needs of our community. Mount Sinai acquired Beth Israel in 2013, and since then, it de-certified 313 beds and eliminated cardiac surgery, maternity, neonatal care, pediatrics, chemical dependency, and rehabilitation services. Financial performance deteriorated across the entire Mount Sinai system, not just at Beth Israel. And by comparison, NYU and New York Presbyterian successfully integrated their acquired hospitals and both systems generated improved operational and financial results. And despite a growing population, particularly in lower Manhattan, Mount Sinai's discharges went down, Bellevue and NYU's went up 49

and 40 percent respectively. So what's going on? We know the management failed. It's really all about the real estate. The Mount Sinai health system stands to gain hundreds of millions of dollars from the sale of Beth Israel property because of zoning changes that became law as part of the state budget earlier this year. These changes increased the value of the property by allowing greater density if these sites are developed for residential use. Further zoning changes under review by this council could further increase the value of properties to as much as one billion dollars at the 18FAR level as the chart behind me shows. It's time to pass LICH, and it's time to figure out a way to keep some of these hospital services, inpatient hospital services downtown, and addressing the community's healthcare needs, not just the cash--

SERGEANT AT ARMS: [interposing] Thank you. Your time expired.

JEANNINE KIELY: Thank you.

CHAIRPERSON NARCISSE: Try to wrap it up. You're done?

JEANNINE KIELY: I'm done.

CHAIRPERSON NARCISSE: Okay, thank you so much. Mario Henry followed by Cynthia Walker.

SERGEANT AT ARMS: You may begin.

CHAIRPERSON NARCISSE: Mario Henry, Cynthia-- followed by Cynthia Walker. Mario?

SERGEANT AT ARMS: You may begin.

CHAIRPERSON NARCISSE: We're moving forward Cynthia Walker.

SERGEANT AT ARMS: You may begin.

CYNTHIA WALKER: Hi, my name is Cynthia Walker. How are you? I just want to say-- oh, Mario's here.

CHAIRPERSON NARCISSE: One second. I think I see Mario.

MARIO HENRY: Hello. I was muted. So I unmuted. I have a brief statement, Chairman Narcisse, Chairman Schulman. My name is Mario Courtano [sic] Henry. I'm a member of the New York Statewide Senior Action Council and a resident of the City of New York all my life. I'm attending this hearing to voice my opposition to the closing of another hospital, Beth Israel, in the City of New York. There was a growing disparity in the number of hospital beds between affluent and low-income

communities. In the last 25 years, over half the hospitals in Queens have closed. As a Flushing resident, there is only one hospital, New York City Hospital Presbyterian Queens, that I can quickly reach in an emergency. My mother, God rest her soul, had access to St. John's Parkway and Mary Immaculate Hospital. The growing shortage of hospital beds, particularly in less affluent communities has a devastating effect on the growing senior citizen population at a time in their lives when they need progressively more medical attention. During the pandemic we saw the tragic terms-- in tragic terms, the consequence of many hospital closings over the last 20 years. The hospital system was overwhelmed. We must assume that there'll be pandemics in the future. We can't assume such events are once in a hundred years, when the ever-expanding world trade market is penetrating into evermore remote parts of the world, making contact with viruses previously isolated. I realizes Beth Israel is in Manhattan and I live in Queens. I do however have reason to travel to lower Manhattan for various reasons. I would hope that if I have a heart attack, if I have a stroke or I get hit by a truck in lower Manhattan, there'll be

a hospital close enough to keep me alive. It's past time to stop closing hospitals in the City of New York. That's my statement.

CHAIRPERSON NARCISSE: Thank you. Cynthia Walker?

SERGEANT AT ARMS: You may begin.

CYNTHIA WALKER: Hi, my name is Cynthia Walker. I'm a registered nurse. Thank you, New York City Council Committee for these hearings on hospital closures. I'm a registered nurse at SUNY Downstate Medical Center in the Telemetry Unit. I've been there for 19 years. SUNY Downstate is dedicated to delivering a lot of services, core services, cardiac care, maternity, pediatric, as well as emergency services which right now there are about 62,000 Brooklynites who visit the emergency room each year. There's 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, under-insured, undocumented individuals, and 20 percent of the population in Brooklyn living in poverty according to U.S. Census Bureau. There's continued effort to educate our policy makers and the community

about significant shortcomings of these closures, cuts in services that would affect the Central Brooklyn community, and the negative impact that this closure would have on the students as well at the Student Medical-- at the SUNY Medical College. Without the hospital, you know-- you can't go to college. You know, you can go to college, but they're tied together, the college and the hospital. They tied-- we have college with all types of disciplines there. Brooklyn Needs Downstate Coalition was composed of AFT, past [sic] different unions and community groups and elected state representatives, and we're dedicated in organizing and educating residents of Brooklyn on the need to maintain and improve SUNY Downstate and will continue to educate policy-makers at the state and federal level that SUNY Downstate should be maintained and--

SERGEANT AT ARMS: [interposing] Thank you. Your time expired.

CYNTHIA WALKER: And residents of Central Brooklyn need additional investment and support. we have diversion because Kings Brook closed, but for-- for them to say that we could just go to Kings County, that's false information, because since Kings

Brooks has closed we've had diversion at SUNY Downstate and as well as Kings County has also had diversion due to do heavy population in the emergency room. So we need to definitely keep--

CHAIRPERSON NARCISSE: [interposing] Thank you.

CYNTHIA WALKER: Work together collaboratively to keep SUNY Downstate open. I thank you.

CHAIRPERSON NARCISSE: Thank you so much. Now we have Tyler Weaver followed by Darcy Dreyer.

SERGEANT AT ARMS: You may begin.

CHAIRPERSON NARCISSE: Tyler?

TYLER WEAVER: Hello, my name is Tyler Weaver. I was an EMT for six years, and I'm here to discuss what affect hospital closures may have on ambulance response time 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 advance life-support paramedic staffed unit. The back-up 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 number one, Bronx ALS response times are much worse than other boroughs such as Manhattan. According to official city data, only 22 percent 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 percent and Brooklyn was 48 percent. This disparity has been going on for years and it is only getting worse. This is a health equity issue. Point number two, the ALS unit for my son was run by St. Barnabas Hospital, but it came from 24 blocks away. The back-up FDNY BLS unit was stationed 66 blocks away. This shows that hospital-run ambulances are a crucial part of City EMS

resources. Point three, 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 even longer travel times. In closing--

SERGEANT AT ARMS: [interposing] Thank you. Your time expired.

TYLER WEAVER: Okay. In closing, as hospital closures are contemplated, 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.

CHAIRPERSON NARCISSE: Thank you. I want to find out if you're coming on Friday, because at 10:00 a.m. we're going to have an interesting hearing for that to know what's going on with the ambulance services and stuff and EMS actually.

TYLER WEAVER: Yes, absolutely. I am signed up to come in via Zoom for that meeting as well.

CHAIRPERSON NARCISSE: Thank you. And if you cannot come, you can always send testimony or do it in Zoom just like you just did.

TYLER WEAVER: Okay. Yeah.

CHAIRPERSON NARCISSE: Alright, thank you.

TYLER WEAVER: Yeah, I'm signed up for Zoom.

CHAIRPERSON NARCISSE: Thank you.

TYLER WEAVER: Thank you.

CHAIRPERSON NARCISSE: Next, Darcy Dreyer.

SERGEANT AT ARMS: You may begin.

DARCY DREYER: Good evening. Thank you to the Council for holding this important discussion. The wave of hospital consolidations across the nation, state, and in New York City has meant that some hospitals have closed entirely while others have shuttered their maternity services. In fact, maternity is often the very first service to close when a hospital is struggling financially. March of Dimes creates every other year a public health data repot on maternity care deserts. National attention to the creation of maternity care deserts have tended to focus on rural areas where pregnant people have no OB providers and no hospitals with OB services, but their closures of maternity services also harm pregnant people in urban areas such as New York City. When Beth Israel Medical Center in lower Manhattan

closed its maternity service in 2018, pregnant people had to scramble to find a place to deliver their babies. Some of them reported overcrowding and chaotic conditions at other hospital's maternity services that were trying to absorb the caseload displaced from Beth Israel, and we know that our communities of color are having much worse outcomes, both infant and maternal outcomes. A recent community survey of people in lower Manhattan who have used Beth Israel asked which services they were most upset that the hospital had closed. One of the top answers was maternity. One lower Manhattan couple reported they were now going to deliver their baby way uptown at New York Presbyterian on 168th Street. While that is still in the same borough, it is a trip that can take up to an hour depending on traffic or mass transit delays, and if you've ever been in labor, an hour is a very long time. Citywide there are 0.17 maternity beds per 1,000 people, but in Queens that number drops to 0.12. That undoubtedly means there is overcrowding on hospital maternity services and challenges in ensuring that people can deliver babies in safe, supportive environments. I urge you to support the passage of the LICH bill which would

ensure that the potential impact of closing a maternity service or the entire hospital would receive strengthened state oversight and consideration--

SERGEANT AT ARMS: [interposing] Thank you. Your time is expired.

DARCY DREYER: of community concerns. Thank you.

CHAIRPERSON NARCISSE: Thank you. And next is Christopher Leon Johnson.

SERGEANT AT ARMS: You may begin.

CHRISTOPHER LEON JOHNSON: Okay, hello everybody. My name is Christopher Leon Johnson. Sorry about the setting. I'm in Rock's [sic] Net [sic], juggling helping somebody out and doing production in like five minutes. So I'm here to testify on behalf of opposing any closures of any hospital. I'm supporting and making sure that Beth Israel on the east side doesn't get closed. I'm here to make sure that the Eye Center on the east side-- like not that far from down there by Kipp's Bay doesn't get closed, and I'm here to make sure that SUNY Downstate doesn't get closed. These hospital closures in the City are nothing but a land grab,

nothing but a big land grab for these developers, just like Open New York for All and [inaudible] open plans. This is all nothing but a property grab because the median rents are down there in those areas, are like $8-$10,000 a month in Manhattan, and in Rita Joseph district rent's about $3-4,000 a month. And they're doing a lot of redesigning around that area by downstate, especially by Flatbush Avenue with the Flatbush bus redesign and the bike lane that y'all pushed out with the help of the Rider's Alliance. So, basically, people need to start opposing these hospital closures, because if you ever get into accident and I don't want this on my dead nearest enemy or any enemy of mine, so any person that hates me, them getting in medical situation in anywhere you going to need a hospital, because you don't-- if you don't get to a hospital in a certain time your condition will get worse, or you might pass away. So, like I said, we need these hospitals because you never know. You might trip and fall and anywhere in the city and you need to go to the nearest hospital because you don't want to trip and fall and be bleeding out or be hurt in your head and you can't get to a hospital because they're closed.

What need to start happening more is we need to get rid of these bike lanes by these hospitals, because that's-- that jeopardize these ambulances. These bus lanes and these bike lanes, we all know what that's about. That's about transportation alternatives and Rider's Alliance who are down with developers and all this is about is redesigning these streets for these developers, and that's all it's about. By the way, we want to save these hospitals, while at the same time we need to get rid of these bike lanes and these bus lanes.

SERGEANT AT ARMS: [interposing] Thank you. Your time expired.

CHRISTOPHER LEON JOHNSON: So, thank you, Chair Narcisse, and please support these resolutions. I know-- like I said, I know [inaudible] I know that the City can't do a lot because these are state hospitals, but I hope that every Council Member support this resolution and we get to the floor. So, thank you so much. Thank you.

CHAIRPERSON NARCISSE: Thank you, Mr. Johnson. The next is Tanesha Grant.

SERGEANT AT ARMS: You may begin.

TANESHA GRANT: Hello, Madam Chair. Thank you so much for this very important committee meeting. I want to talk from a personal experience. Last year I had perfiotic [sic] appendicitis which basically meant that my-- that-- oh, I'm losing my words here. It basically meant that my appendix had a hole in it and it was leaking into my large intestine. So even in my neighborhood when I went to the hospital, I was in the hospital for 10 days. It was a life-threatening thing that happened to me, and I had to wait in the ER for four days before I got a bed. Just last week my son had a very serious condition with his scalp. I called his primary doctor to get him an appointment, and they told me that i had to take my son to the ER because they had no available appointments. When we're talking about Medicaid payments, these health officials do not get paid what they should with Medicaid or any of these programs or these assurances that we're on. And what does that mean for the healthcare that we get? We should not be closing any hospitals, especially in high-needs areas where good healthcare is at our lap already. It is outrageous to me that in a city of eight million people, a city that our budget, our

city budget is $115 billion and our state budget is over $220 billion, yet, through all the bureaucracy we can't make sure that everyone has a good hospital in their neighborhood. It is outrageous and it's ridiculous. So we are demanding that City Council urges the state to not close this hospital in the lower east side, and also not only keep our hospital open, but enhance them and give--

SERGEANT AT ARMS: [interposing] Thank you. Your time expired.

TANESHA GRANT: us all the healthcare services that we deserve. Thank you for listening to my testimony.

CHAIRPERSON NARCISSE: Thank you so much. The next is Benjamin Wetzler.

SERGEANT AT ARMS: You may begin.

BENJAMIN WETZLER: Hey, can you hear me? Can you hear me?

SERGEANT AT ARMS: Yes, we hear you.

BENJAMIN WETZLER: Oh, okay. Great. I wasn't sure. I was having some issues earlier. Hi, my name is Ben Wetzler. I'm a resident of Stuyvesant Town and I'm here to voice support for Council Member Rivera's resolution and ask the Council to keep Mount

Sinai Beth Israel open and to do everything that they can to make sure that that happens. Our community really relies on this institution. It's important. It provides all number of different types of care, but most importantly is the full service emergency room. Without a full service emergency room we are at risk of very long wait time for essential care that our neighbors can't afford. They told us that the approval of the closure is conditional on capacity at some of the other hospitals in the neighborhood, but you know, there are a lot of problems with that. Not everybody's insurance will cover the-- you know, not every type of hospital, they won't necessarily be able to do it, and I really just think that that is an insufficient commitment to the neighborhood and to our needs. I also want to echo what was said by some of the other speakers about concentration of hospital facilities in different neighborhoods, notably the ones uptown. I grew up on the upper east side. I was born at Lenox Hill Hospital. My parents have had a lot of lifesaving care there. I think that those facilities are very important and they're valuable to the community, but every neighborhood needs one of these. We shouldn't just have all of them being

pushed into the same neighborhood. It's very disconcerting that as some of the people talked about earlier, billions of dollars are potentially being invested into a new facility on the upper east side while Beth Israel is at risk of closing. So I definitely am glad to hear that the Council is talking about comprehensive citywide planning for these types of facilities. I want to make sure that we ensure that every neighborhood has an appropriately sized facility that's meeting its needs, and I hope that you'll act accordingly and support the resolution. Thank you.

CHAIRPERSON NARCISSE: Thank you. And the next person is Sarah Batchu.

SERGEANT AT ARMS: You may begin.

CHAIRPERSON NARCISSE: If-- we are making a final call for the Zoom registrant who have not yet spoken. If you're there, please raise your hand if you wish to speak. I guess there's no one. I'll staff will unmute you if you're here. No? Seeing no hands, I would like to know that everyone can submit written testimony to testimony@council.nyc.gov within 72 hours of this hearing. To conclude, I would like to thank everyone who has taken the time to testify

today. Thanks to the healthcare professionals, the unions, everyone that came out who take care. This is how we do it in New York, to take care of each other. And I thank you. Thank the staff, everyone here, my colleagues that stay here, Chair Schulman, Rivera and all the Sergeants, everyone that contributed to make this possible. In addition, I would like to take this moment to express my thanks to our state level elected officials who attended today's hearing and extend our gratitude for the actions they have been taking to protect our shared constituents. Thank you all, and-- so much for the work we do. With that, this hearing-- oh my colleague want to add something before I conclude.

CHAIRPERSON SCHULMAN: Yes, before we conclude, conclude, I want to thank everyone that testified today. It's a really important topic. There are a number of things that we can do and will do to make sure that we not only keep the hospitals we have but we expand hospital capacity and do it equitably. And I want to thank my colleague Chair Narcisse for today's hearing and the committee staff and my staff. So, thank you very much.

CHAIRPERSON NARCISSE: So, now I would like to add the policy analyst, Mahnoor Butt. Thank you [inaudible] Counsel, [inaudible]. I also want to thank my staff Saye Joseph and Frank Shea for their support for this hearing. And thank you all so much for all the work you do to make this New York City and address the inequities in healthcare. With that, this hearing is now concluded.

[gavel]

C E R T I F I C A T E

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

Date November 7, 2024