1
2 CITY COUNCIL
CITY OF NEW YORK
3
------------------------ X
4
TRANSCRIPT OF THE MINUTES
5
Of the
6
COMMITTEE ON HOSPITALS
7
October 3, 2018
8 Start: 2:15 p.m.
Recess: 5:06 p.m.
9

10 HELD AT: Council Chambers – City Hall

11 B E F O R E: CARLINA RIVERA
Chairperson
12
COUNCIL MEMBERS:
13 DIANA AYALA
MATHIEU EUGENE
14 MARK LEVINE
ALAN N. MAISEL
15 FRANCISCO P. MOYA
ANTONIO REYNOSO
16
17
18
19
20
21
22
23
24
25

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

Matt Siegler
Senior Vice President, Managed Care, Patient Growth, and Interim Lead for Government and Community Relations at New York City Health and Hospitals

David Rich
Executive Vice President for Government Affairs, Communications, and Public Policy at the Greater New York Hospital Association, GNYHA

Lois Uttley
Director of Women's Health for Community Catalyst And the Founder of the Merger Watch Project

Judy Wessler
Director of the Commission on the Public's Health System

Arthur Schwartz
Treasurer and Political Director of New York Progressive Action Network

Heidi Siegfried
Health Policy Director at Center for Independence Of the Disabled in New York

Katelyn Hosey
Public Policy Associate from Live On New York

Mark Hannay
Director of Metro New York Health Care for All

[gavel]

CHAIRPERSON RIVERA: Good afternoon everyone. I am Council Member Carlina Rivera, Chair of the Committee on Hospitals and I'd like to start off by thanking my colleagues and fellow members of the committee for joining us today. Today we'll hear from representatives of Health and Hospitals and other stakeholders about the ongoing transformations occurring in the way care is delivered in our health care system. These changes impact everyone of us. Access to adequate health care is a fundamental, human right and we must ensure that every New Yorker has access to quality, affordable care. Hospitals are in the process of transforming the way they provide care to communities by expanding the availability of outpatient and community-based services while concurrently reducing inpatient capacity. Additionally, the delivery system reform incentive payment or DSRIP program has fundamentally changed the way many receive their care. DSRIP focuses on reducing avoidable hospitalizations and providing more value based and patient centered care by allowing hospitals, providers and community-based organizations to work together to provide individuals

with Medicaid and those who are uninsured with higher quality and more effective care. The basis for health care transformation including DSRIP centers around a triple aim providing better care for individuals bettering the overall health of the population and lowering costs by improving health care. As the Chair of the Hospitals Committee and a member of the community that has been experiencing significant changes in the way health care services are provided, I want to ensure that health system transformations are positively and meaningfully changing the lives of those who need care. While there are individuals who are receiving more coordinated care as a result of these changes, there are many of us who remain concerned. Many of us here today are also familiar with the transformation of Mount Sinai Beth Israel. In May of 2016, the Mount Sinai system announced plans to close the 800 bed Mount Sinai Beth Israel Medical Center and replace it with a new 70 bed Mount Sinai downtown Beth Israel Hospital and Emergency Room with a network of outpatient centers and doctor's offices. As someone who has been vocal throughout this process, the closure of departments over the past couple of years has led to increased

2 anxiety within the community about the availability
3 of services. This hospital is very important to my
4 district and, and to the city and we saw the impact
5 that the closure of Saint Vincent's had on not just
6 Beth Israel but our public… our public hospital down
7 the street Bellevue. As a former member of the
8 Bellevue Community Advisory Board, our focus on that
9 board was always patient care and advocacy first and
10 that was constantly challenged as this facility
11 continued to face financial strain in the largest
12 system and an expectation from voluntary hospitals
13 that those uninsured, underinsured and not near
14 another voluntary hospital could go to H and H
15 instead but this downsizing and transformation of
16 Mount Sinai Beth Israel is not alone in this wave of
17 change. According to the state Department of Health
18 78 hospital mergers or acquisitions were approved or
19 pending between 2011 and September 2017 and 764
20 hospital beds were lost between 2015 and 2017
21 throughout the state. Although this transformation
22 process is regulated by the state, we the
23 representatives of those who will face the effects of
24 such changes must and will take the time to examine
25 this process and its impact on vulnerable populations

2 in our community as a whole. Today we want to examine
3 these transformations, understand the context in
4 which they are occurring, discuss their impacts and
5 explore the level of community engagement involved in
6 these processes. To best meet, meet the needs of the
7 community; the community itself, patients, providers
8 and advocates must be at the decision-making table.
9 As health care continues to change we must ensure
10 that individuals and communities retain access to
11 care that meets their needs. Our health care system
12 is very complicated and has many moving parts.
13 Today's hearing is a great opportunity to hear about
14 many of the ways in which our health care providers
15 are improving the care of those they serve as well as
16 potential areas for improvement. I'd like to thank
17 those who are here to testify today including
18 representatives from Hospitals as well as community
19 members and advocates. It is crucial to have all
20 stakeholders at the table for this discussion
21 including physicians, advocates, patients and
22 hospital representatives. I look forward to our
23 robust discussion. So, first… okay, great. No, you…
24 alright, I'll do it. So, I want to thank the
25 administration for being here and before we begin

2 just to swear you in. Do you affirm to tell the
3 truth, the whole truth and nothing but the truth in
4 your testimony before this committee and to respond
5 honestly to council member questions?
6 MATT SIEGLER: I do.
7 CHAIRPERSON RIVERA: Thank you.
8 MATT SIEGLER: Well thank you very much
9 for having me. Good afternoon Chairperson Rivera and
10 members of the Committee. And my name is Matt
11 Siegler, I'm the Senior Vice President at Health and
12 Hospitals and the Managed Care, Patient Growth and
13 I'm our Interim Leader for Government and Community
14 Relations. I really appreciate the opportunity to
15 testify here today and on behalf of Dr. Katz I want
16 to apologize that he's not able to be here, every
17 Wednesday afternoon he sees patients as a primary
18 care doctor at our Gouverneur Health Center which is
19 just a mile or so up the road from here, next to the
20 East Broadway stop so if you don't have a primary
21 care doctor or you've never been to Gouverneur and
22 just want to check it out, it's a beautiful facility
23 and I hope you go have a look at it but he's very
24 committed to his patients and so we're, we're pleased
25 that he's there but he's… unfortunately could not be

2 here today. I'm joined by Bridgette Ingraham from our
3 Government Community Relations team, hopefully you
4 and your staffs know Bridgette and work with her
5 closely and I'm also joined by our Vice President for
6 Primary Care, Dr. Ted Long, who Dr. Katz described to
7 me today as a more enthusiastic and energetic version
8 of Dr. Katz if you think that's possible. So, I hope
9 you get a chance to meet Ted and he can tour you
10 around some of our ambulatory care sites around the
11 city. This hearing addresses a timely and important
12 topic for Health and Hospitals and for the broader
13 health care industry as, as the Chair mentioned
14 through advances in medical practice and technology
15 as well as a better understanding on how to deliver
16 care efficiently and effectively. More care is moving
17 from the inpatient settings to the outpatient or even
18 virtual settings, telemedicine and new technologies
19 like that. The shift is a welcome change for both
20 patients and clinicians. The more safe and convenient
21 we can make it for patients to get their care the
22 sooner we can get them home, if they do need to come
23 to the hospital the better it is for patients and for
24 the health system overall. And, and Health and
25 Hospitals is, is all in on this change, we're

2 committed to making this change and it's… into
3 serving our patients in this way. In 2016, the, the
4 city correctly identified this trend and, and
5 capitalizing on it as key to Health and Hospitals
6 future. The one New York Health Care for our
7 Neighborhood Report presented a comprehensive plan to
8 transform Health and Hospitals into a high
9 performing, competitive and sustainable community-
10 based system. As noted in the report and in
11 subsequent data release by our system, inpatient
12 hospital stays have declined in recent years, they've
13 declined at Health and Hospitals as well as in the
14 broader industry and while we've seen some of these
15 downward trends at Health and Hospitals level out in
16 recent years as we've begun to in, invest in new
17 clinical capability, the shift away from inpatient
18 care to outpatient care is continuing and, and will
19 continue. So, we need to transform our public health
20 system to better serve our patients of communities by
21 enhancing access to ambulatory care services, by
22 addressing social determinates of health, and by
23 restructuring our clinical services to provide 21st
24 century health care for all New Yorkers. One
25 challenge with this transition to outpatient care is

1
2 making sure the financial incentives are aligned.
3 Historically, the financial model in American health
4 care was for doctors and hospitals to bill on a fee
5 for service basis. That essentially means that the
6 more care delivered and the more expensive the care
7 delivered, the better a provider could do
8 financially. Thankfully, we are taking steps in New
9 York State and around the country towards paying for
10 the value of the care delivered, not just the
11 quantity of that care. As the Chair mentioned the
12 state's delivery system reform incentive payment
13 program or DSRIP is one reflection of this shift. The
14 goal to reduce avoidable hospitalizations by 25
15 percent and restructure the health care delivery
16 system are critically important and Health and
17 Hospitals is very focused on it. The move away from
18 unnecessary emergency department visits, from
19 unnecessary readmissions, from unnecessary
20 hospitalizations have a critical financial impact on
21 Health and Hospitals and all hospitals involved in
22 the program and, and are very important. So, that
23 shift does require significant changes in staffing
24 and the culture of health care delivery systems.
25 While, you know some hospitals continue to compete

2 for patients based on expensive tests and
3 consultations with specialists and patient stays,
4 that’s not Health and Hospital’s focus, we are
5 committed to value based payment and delivering
6 efficient high value care. And I think we’re well
7 positioned to capitalize on this shift for, for a
8 number of reasons. Our physicians are largely
9 salaried meaning they have no incentive to deliver
10 expensive and unnecessary care just for the financial
11 impact and much of our business comes through risk-
12 based contracts meaning we share in the savings if we
13 deliver efficient and high-quality care. One
14 additional way I think we’re well positioned to
15 capitalize on this is our connection to the
16 community. I spent last night with our counsel of
17 community advisory boards, I know the, the Chair was
18 a member of the Bellevue CAB and that connection to
19 the community and investment in our hospitals I think
20 is critical to making sure we capitalize on this
21 shift outpatient care and, and can deliver a good
22 care that’s valuable to the community. So, you know
23 despite these structural advantages, capitalizing on
24 this shift does require significant changes and Dr.
25 Katz has shared with the committee in the past his

2 goal is to accelerate the transformation of our
3 system in order to ensure its long term stability by
4 focusing on three critical priorities: investing in
5 and expanding primary care, improving access to much
6 needed specialty care and achieving fiscal solvency
7 for the system and these goals are connected
8 obviously. In recent months, thanks to the generous
9 support of the Mayor, the Council and other elected
10 officials we've opened a new community health center
11 on Staten Island, we've renovated and reopened
12 another community health center in Lower Manhattan
13 and we continued our efforts to use technology to
14 expand access to needed specialty care. In July, we
15 opened Health and Hospitals first full-service
16 ambulatory care center on Staten Island, NYC Health
17 and Hospitals Gotham Health Vanderbilt's its name,
18 it's going to expand access to primary care for
19 clinicians and adults, mental health counseling and
20 referrals, opioid treatment and other services. In
21 August I was thrilled to see the, the Chair at a
22 celebration of the modernization and reopening of our
23 Gotham Roberto Clemente Center, which has provided
24 care to Manhattan's Lower East Side for 30 years. The
25 health center provided expanded access to a central

2 primary care and behavior health services. In that
3 same time, we've continued to expand our use of our
4 e-consult system, which allows primary care doctors
5 to get specialist's opinions on their patients
6 virtually. Now instead of waiting weeks or longer for
7 a specialist appointment, a primary care doctor can
8 get a specialist consultation within hours or a
9 couple of days. We've more than doubled the number of
10 e-consults occurring across our system in the past
11 year and we're thrilled to use this technology to
12 continue… to expand specialty access outside the four
13 walls of the hospital. Going forward, we're launching
14 a series of strategic initiatives designed to
15 transform our health system's vast ambulatory care
16 operation, improve access to in demand primary and
17 specialty care, and reverse the recent trend of
18 declining outpatient visits. We've just announced as
19 of this morning a five-point strategy that will
20 become adopted across our public health system's more
21 than 70 community-based health centers and hospitals
22 and together they provide more than five million
23 outpatient visits to children and adults every year.
24 The plan is focused on five key priorities: one is to
25 fix the continuity of care, to build fidelity with an

2 assigned primary care physician, that’s all about
3 making sure you’re seeing your primary care doctor
4 every time you come in for a visit, if you see a new
5 primary care doctor every time it’s difficult to
6 build that relationship that really improves care and
7 make sure you have that familiarity and connection.
8 The second goal of the five point plan is to reduce
9 no show rates, a large percentage of the appointments
10 that are made in our system patients are either… the
11 appointments are so far out or they don’t work for
12 the person’s schedule that there’s a no show rate and
13 that creates problems in how our clinics flow and how
14 they function so we want to reduce that with
15 technology like sending people text messages and
16 reminding them of their appointments and scheduling
17 visits same day or next day by leaving some open
18 slots in the scheduling system. Next, we want to
19 expand our use or e-consult as we’ve talked about in
20 the past, so having… making sure you can get a good
21 specialty consult and opinion through a visit to your
22 primary care doctor is a critical way to improve our
23 ambulatory care system and we’re hyper focused on
24 that. Next we want to make sure that all of our
25 clinicians in the outpatient setting are practicing

2 at the top of their license, so making sure nurses
3 are doing what… everything nurses are capable of
4 doing, doctors are doing what doctors are doing and
5 all the support staff handle the necessary work for
6 them, we don't want… you know doctors are not…
7 doctors do everything in our system, they're, they're
8 not above any kind of work but having a doctor, you
9 know answer the phone or do things like that is not
10 the best use of that clinician's time, we need them
11 seeing patients as much as possible and really
12 working to improve health. And then finally, a… we
13 have to have… improving billing and coding and
14 insurance verification as a part of any strategy in
15 our ambulatory care setting, making sure that Health
16 and Hospitals gets paid fairly by insurance companies
17 is a critical part of our… of our transformation plan
18 so that's part of our ambulatory care plan as well.
19 So, from these steps to improve ambulatory care, to
20 our new partnerships with city agencies, community
21 groups to address social determinants of health,
22 we're committed to delivering high quality care where
23 and when our patients need it. We know that there
24 will always be a need for inpatient hospitals and the
25 critical role that our facilities play in their

2 communities cannot be overstated. But moving towards
3 a community-based care model will deliver better care
4 at lower costs and we're committed to partnering with
5 our staff, our providers and this committee to
6 changing in this changing marketplace. So, again I
7 appreciate the opportunity to testify here today and
8 I look forward to your questions. Thank you.
9 CHAIRPERSON RIVERA: Okay, great, thank
10 you so much. I, I wanted to quickly thank every,
11 every… people in the health care system
12 specifically at Bellevue. We had a fire in my
13 district this morning and there were a number of
14 people injured and so I wanted to thank you and
15 all of the first responders who were there on
16 scene through the night and that will remain there
17 so, so thank you for, for that. So, I wanted to
18 ask… oh, yeah, I wanted to recognize my Council
19 Members who are here, who have joined me including
20 Council Member Maisel, Council Member Reynoso,
21 Council Member Levine, Council Member Ayala and
22 Council Member Moya. So, before I turn to my
23 colleagues I know a couple of them have questions,
24 I wanted to ask a few things of course. Clearly we
25 are here because of the transformation and because

we, we do have a lot of questions not just of H and H but of the voluntary hospital system and your relationship, which I really do think is dependent on the other, I think we do need both to serve every single New Yorker that walks into its doors to ensure that we have a healthy city and I know that that's not always the case and so we're here to talk a little bit about some of the, the hospitals that have closed and who are downsizing and how that's going to actually affect how you provide services. So, I had a couple of general questions. So, why is outpatient community-based health care often times more effective than inpatient care?

MATT SIEGLER: Well I think it's a great question and, and you know inpatient care is certainly more effective for certain things, right, I, I think trauma surgery and, and basic procedures that require long hospital stays you, you can't do that on an outpatient basis but I think a, a simple answer and I'm not a clinician so my… Doctor Katz can correct me after the fact but, you know the, the simple reason is that people can do better recovering at home, getting

2 home from hospitals is, is better for people's
3 recovery and then I think on the primary care
4 basis, the basis from my perspective of any good
5 health care system is making sure people are
6 getting in and getting preventative care, staying
7 ahead of health issues before they arise and you
8 can't really stay ahead of health care issues if
9 you're focused on an inpatient hospital stay,
10 right, you need people to get into primary care,
11 see a doctor on an ongoing basis, take their
12 medications and that can and all should be done on
13 an outpatient basis so, you know meeting patients
14 where they are, making sure you're getting ahead
15 of health issues before they arise, I'd say that's
16 probably the foundation of why it's important to
17 have a strong outpatient system.
18 CHAIRPERSON RIVERA: How has H and H
19 shifted its resources to kind of accommodate this
20 transition?
21 MATT SIEGLER: That's… we're, we're hyper
22 focused on it and, and… across the care continuum,
23 we're hiring primary care doctors at a… at a rapid
24 pace as quickly as we can, you know continuing to
25 invest in our inpatient facilities because we…

2 they are such critical parts of the community and
3 to deliver very necessary services but our focus
4 on hiring primary doctors, on building outpatient
5 facilities not just in Staten Island as we did in
6 July but around the city, that's a real shift of
7 resources and a focus for us so investing in new
8 sites, investing in new doctors and putting the
9 technology in place to make sure that we connect
10 our outpatient centers to the broader health care
11 system.
12 CHAIRPERSON RIVERA: So, you brought up
13 two, two things that I think are important; one is
14 you, you brought up primary care physicians which,
15 which I agree that it's important to have a
16 primary care physician who gets to know their
17 patient over time and who's there to answer
18 questions instead of someone coming in with a
19 common cold into the emergency room and there are
20 a lot of factors that influence why someone would
21 come into the emergency room for a common cold but
22 there, there's a shortage of doctors as well in
23 terms of primary care physicians so how are you
24 going about… I guess responding or reacting to
25 that issue when… I know it puts a tremendous

2 amount of pressure on, on the nurses that are in
3 the hospital so how is H and H responding to, to
4 that shortage and, and kind of what are you doing
5 to make sure that all of the people inside your
6 hospitals have the mental and physical capacity to
7 serve patients at 100 percent?
8 MATT SIEGLER: Yeah, it's, it's a
9 critical issue and you know it's difficult to be a
10 doctor in, in the United States and it's difficult
11 to be a doctor in, in New York City so we are
12 committed to supporting our clinicians and Doctor
13 Long and Doctor Katz have a great recruitment
14 campaign for primary care physicians, DOCS for NYC
15 is its name, there's YouTube videos and catchy
16 fliers and great things, we've, we've got a, a
17 tremendous advantage actually as Health and
18 Hospitals for recruiting physicians because we
19 have a mission and a patient population really
20 like no other. The ability to really change the
21 trajectory of people's lives through your care as
22 a practicing primary care doctor is unique in our
23 system and the care that our clinicians who
24 already work here have for the system, the
25 commitment of the community to our system and the

2 investment in it is a… is a really wonderful and
3 important thing and so, you know mission driven
4 doctors like that are just looking for us to reach
5 out and looking for us to make it easier for them
6 to practice in our system. When you have an
7 electronic health record that's very difficult to
8 use, when you have outdated things like time
9 sheets or people don't answer the phone when they
10 call the clinic these basic things that Doctor
11 Katz and our whole team are so focused on fixing
12 those are key recruitment tools for physicians and
13 they're a critical part of transforming the
14 system, they're, they're the bread and butter,
15 they're the fundamentals but they're really,
16 really important so I'd say direct recruitment
17 efforts, putting a lot more focus on that and
18 getting out there and being visible with people is
19 one thing and then making the system more
20 welcoming and easy to work in because you know
21 it's, it's tough to be a, a doctor in any setting,
22 I couldn't do it and I'm, I'm not a clinician, I
23 don't pretend to be one but you know doing
24 everything we can to support that is a… is a key
25 part of that effort.

2 CHAIRPERSON RIVERA: So, you… in terms
3 of… you know mentioned in your testimony, you… in
4 your testimony that between 2012 and 2014 Health
5 and Hospitals experienced declines in hospital
6 stays, losing nearly five percent or 10,000 of its
7 hospital stays, so, I would hope that as you focus
8 on primary care that you're seeing maybe people
9 going to more community based clinics which is
10 really what your Gotham Health Network is all
11 about and so Doctor Katz even identified the need
12 to invigorate and expand primary care as the main
13 priority of the H and H system however utilization
14 across the, the Gotham Centers decreased by 5.6
15 percent in the last… in fiscal year 2018 with five
16 of the six sites reporting fewer patients compared
17 to the year before, so given the impetus on
18 addressing the primary care needs of families and
19 individuals in their own neighborhoods why do you
20 think New Yorkers aren't utilizing the Gotham… the
21 system… the system as much as we'd like?
22 MATT SIEGLER: Yeah, I, I think you've
23 identified a critical issue, it's something we are
24 hyper focused on addressing. I think one clear
25 answer to, to that trend is, is the physician

2 recruitment pieces, right, we've got to make sure
3 we have the right number of staff, the right
4 number of doctors and support staff in those
5 facilities to welcome people and make it easy to
6 get an appointment when you need one, we've got to
7 have the systems in place to make it easy to get
8 into the system and have it be coordinated. For
9 instance, I… my primary care doctor is at Bellevue
10 but there is a Gotham site closer to my home and
11 it wasn't easy for me to try to change my primary
12 care doctor from Bellevue to that Gotham site, so
13 we've got to do a better job at that and we're
14 working on things like that at our call center,
15 with Metro Plus and our other health plan partners
16 but leveling out that trend which I think we're
17 starting to see this year the rate of decline is
18 slowing and we're going to move towards growth in
19 the next year or so but you've identified the
20 critical challenge, we've got to make sure that
21 we're growing our patient based in and outpatient
22 care by keeping the patients that we have, I mean
23 we have a, a loyal and important base of patients
24 and so making sure it's easier to use our system
25

2 and that we're executing on those fundamentals
3 really is the key.
4 CHAIRPERSON RIVERA: So, I've been trying
5 to get to, to every hospital in the city and I'm
6 slowly making my way to every borough and a lot of
7 the hospitals of course one way that the council
8 can exercise its charter mandated responsibility
9 of oversight is some of the capital funds that are
10 going into some of these buildings and for those
11 buildings that are underutilized or that have
12 space or maybe their emergency rooms aren't at
13 full capacity they are still looking to renovate
14 and improve the facilities which I think is
15 absolutely necessary, anyone who comes into a
16 hospital should feel like they have one of the
17 most beautiful hospitals in the city and we do
18 have some great looking hospitals and of course
19 Bellevue is absolutely one of them but do you
20 think that the… in, in terms of, of capital, so
21 you have a. a capital commitment… a capital
22 commitment plan, 2.8 billion in the fiscal year
23 2018 to 2022 with 90 percent of the porting…
24 funding supporting hospital improvement projects,
25 so how can H and H improve its capital plan,

2 planning in spending to best address the changes
3 in health care delivery specifically the move
4 towards outpatient services and while I, I say
5 this because in Woodhull they were looking… they
6 are looking to renovate their emergency department
7 and expand and I’m wondering whether that is the
8 best use of funds considering the utilization of
9 that room. Now there are other hospitals and, and
10 my, my colleagues are probably going to speak of
11 the hospitals in their district that are at full
12 capacity if not over capacity and so are you
13 looking at each individual hospital and how you’re
14 spending these capital dollars because the one
15 other thing that I hope that improves over the
16 next few years is the transparency by Health and
17 Hospitals in terms of your financial planning even
18 having a capital plan for the next five years,
19 we’d love to see those numbers as soon as
20 possible. So, so how are you looking to use those
21 funds in this shift towards outpatient care?
22 MATT SIEGLER: Well I think you’re…
23 that’s exactly right, you’ve got to look at it
24 holistically, right, we have to make sure that the
25 hospitals which are such a critical pillar of our

2 communities have the services and infrastructure
3 that they need to function well and… but the
4 council and the Mayor have been very supportive in
5 that shift towards outpatient care so 100 million
6 dollars committed to new outpatient care sites,
7 very excited about that, the Caring Neighborhoods
8 Initiative done tremendous work in building new
9 outpatient facilities and focusing our resources
10 there. So, I look forward to working with you on
11 the capital plan in making sure that we're looking
12 at this holistically because I think you're… it's,
13 it's an excellent point and we'd certainly want to
14 make sure that our resources are focused on the
15 direction that health care is going and that our
16 system is going.
17 CHAIRPERSON RIVERA: Has the
18 consolidation of the voluntary hospitals affected
19 Health and Hospitals?
20 MATT SIEGLER: I… you know I think the
21 health care market is evolving around the city and
22 I'm certain that there has been change as patients
23 move between facilities and facility footprints
24 change, you know I, I, I can't speak to the
25 broader trends, before I arrived I, I came in from

2 Los Angeles with Doctor Katz just nine or ten
3 months ago although it feels like we've been here
4 a, a long, long time and, and learned a lot from
5 this community and, and feel so lucky to be a part
6 of it but certainly Health and Hospitals is a
7 critical part of the safety net and a pillar of
8 the health care industry in this city so any
9 changes that happen in any borough do have an
10 impact on Health and Hospitals and what doesn't
11 change though is our commitment to our patients
12 and our commitment to serving everybody who comes
13 through our door regardless of their ability to
14 pay. So, you know our focus is squarely on that
15 and on making sure we get our internal systems and
16 structures in order so that we're delivering that
17 high-quality patient care and, and keeping
18 ourselves on good financial footing.
19 CHAIRPERSON RIVERA: Well let's, let's
20 get a little specific if you can, that was a very
21 good general answer. I wanted to ask… so, we had a
22 hearing at… in Del Barrio about the future of
23 psychiatric care in New York City and a couple of
24 things were brought up in terms of the Allen
25 Pavilion at Presby, eliminating behavioral health

2 beds and you know to Mount Sinai Beth Israel's
3 credit they are keeping 200 behavioral health beds
4 during this transformation which is still scary
5 but they are keeping the behavioral health beds
6 which are sorely needed and so we had this hearing
7 and we heard that there was a rise of inpatient
8 psychiatric care at Health and Hospitals because
9 we know when we look at costs and the bottom line
10 that this is just something I feel like H and H
11 has had to take on year after year so have you
12 seen an increase in any other inpatient services
13 besides psychiatric care because of the change in
14 the way the voluntary hospitals are… what they're
15 going through in their transformations?
16 MATT SIEGLER: You know I think that is…
17 that is a critical example and one that we're very
18 focused on, you know our… there are… the trends in
19 that service line are certainly more significant
20 than I think in others and I can get you a more
21 detailed list of specific changes by service line
22 but our commitment to behavioral health is there
23 regardless of what our competitors are doing and I
24 know Doctor Barron was at that hearing at… in Del
25 Barrio and, you know he does a tremendous job and

2 our clinicians are very focused on these… on that
3 service line and we will continue to be so, you
4 know our, our inpatient facilities, it varies year
5 to year. I think certainly emergency department
6 and, you know AmSurg and surgery coming in through
7 the ED's have changed and increased in recent
8 years but again attributing that to specific
9 changes in the market is a… probably more specific
10 than I can get in to setting right now but I'm
11 happy to follow up with you and, and dig into more
12 details on it.
13 CHAIRPERSON RIVERA: So, do you have any
14 like numbers you can give us? I only feel… I say
15 this… and Matt you said you came from LA, right,
16 he like… [cross-talk]
17 MATT SIEGLER: I didn't work with Doctor
18 Katz… [cross-talk]
19 CHAIRPERSON RIVERA: No, no, he gave… he
20 called you, you got the call?
21 MATT SIEGLER: I got the call, I got the…
22 [cross-talk]
23 CHAIRPERSON RIVERA: Okay… [cross-talk]
24 MATT SIEGLER: …call.
25

2 CHAIRPERSON RIVERA: …and that's, that's
3 good, the, the… you have a rapport and I think
4 that's important in terms of getting to work and,
5 and… as soon as we can, this is a big system and
6 there's a lot to fix. And so, why I'm asking is
7 because, you know I've had a lot of conversations
8 about Doctor Katz and I'm glad that he's at, at
9 the hospital and he's seeing patients, I think
10 that's important so… you know but you being here,
11 you know we've talked a lot about, you know
12 utilizing under, underutilized space and thinking
13 about that and I… and, and I… and I know you said
14 that you've seen some increases but do you have
15 any numbers, any data because I made the comment
16 earlier about transparency and having statistics
17 and… if you can maybe give us one example, if
18 it's… [cross-talk]
19 MATT SIEGLER: Sure… [cross-talk]
20 CHAIRPERSON RIVERA: …if it's… if it's
21 surgery, if it's… whatever it is.
22 MATT SIEGLER: Sure, my, my… [cross-talk]
23 CHAIRPERSON RIVERA: If we can… [cross-
24 talk]
25

2 MATT SIEGLER: …I'm happy to, my, my
3 recall is not as… is not as precise as Doctor
4 Katz's and he's got an encyclopedic knowledge of
5 our facilities as a clinician, but I've got some
6 notes here that I'll just… I'll, I'll give you
7 that. One of the largest increases was, was cancer
8 center services across our facilities, that's a
9 20,000 increase from FY '14 to FY '18, dental
10 services and geriatric care have also gone up,
11 ophthalmology services are up. I can get you
12 specific details on those, you know the most
13 important decline in services that, that we've
14 talked about is in primary care, right, that's a
15 big base of patients and that has gone down almost
16 12 percent since FY '14. So, that's the number
17 that I'm most focused on, making sure we turn that
18 number around, flatten it out and, and bring it up
19 is a… is a critical part of this and then I think,
20 you know you, you, you drew out… you drew out a
21 great example which is behavioral health. I think
22 we deliver a tremendous amount of it but there is
23 an unmet need in the community for it and finding
24 new models to deliver that in a holistic way,
25 connect people to the services they need. I think

there's a lot of important ways we could use our hospitals as, you know important parts of the community to connect people to those services and, you know grow that service line in a sustainable way.

CHAIRPERSON RIVERA: So, generally cancer, dental, geriatric, ophthalmology are up; primary care down?

MATT SIEGLER: Correct.

CHAIRPERSON RIVERA: Okay, I just ask that in the future if we could… if you could bring some numbers so we can kind of be able to also when we have a conversation with the voluntary hospitals and say, you know there are real increases in… we… we… you know just saying there's increases but having the numbers you, you know a lot… many conversations are data driven especially in health care.

MATT SIEGLER: Absolutely.

CHAIRPERSON RIVERA: So, I have some more questions, but I want to actually pass, pass the mic to my colleagues to make sure that they are able to ask, ask you. So, first I want to acknowledge Council Member Levine.

2 COUNCIL MEMBER LEVINE: Thank you Chair
3 Rivera for convening this hearing on such an
4 important topic and for your incredible work
5 chairing the committee and it's great to chat with
6 H and H, you know these, these are times of
7 tectonic changes in health care as we've been
8 discussing here and H and H has been impacted
9 deeply by that and we're worried about the
10 institution of our public hospitals because they
11 are critical to life in this city. They're also by
12 the way critical to the voluntary hospitals, if,
13 if H and H didn't exist it would be a huge problem
14 for the entire medical system and as, as the Chair
15 was, was, was very ably summarizing there's almost
16 no aspect of your work that isn't seeing an
17 increase or a decrease or a transformation. You
18 have inpatient which was a significant decrease,
19 you have smaller decreases in the community based
20 facilities, emergency room use I believe continues
21 to be quite robust, I'm not sure if it's
22 increasing but it's, it's, it's intense usage and
23 you have… you have a… an inventory of buildings
24 that were built anywhere from mostly 40 to 100
25 years ago and I got to imagine that is creating a

2 lot of mismatches and in, in particular I know
3 that there are hospitals with a significant
4 inventory of vacant inpatient beds and I wonder if
5 you could talk about that, the mismatch to the
6 extent that you're experiencing it between
7 buildings that, that you've inherited and the
8 changing world of patient services.
9 MATT SIEGLER: Sure, sure, happy to. I, I
10 think… you know hospitals were built bigger
11 previously, right, several hundred beds, I think
12 Bellevue is 900 beds and you know that scale and
13 size is certainly different than what people are
14 building when they build a new hospital now, you
15 know from I think a… our perspective however these
16 are critical community institutions and I don't
17 look at it as much as empty beds or empty floors
18 but as critical space in a community institution
19 where we can deliver health care of all kinds and
20 you know I, I come to Health and Hospitals from a,
21 a health care system in California called Kaiser
22 Permanente which was built a lot on one stop
23 shops, right, so there is not a perfect singular
24 model for how you should deliver health care but
25 having inpatient, outpatient, pharmacy, all kinds

2 of a variety of clinical capabilities in one
3 setting does have value so we… [cross-talk]
4 COUNCIL MEMBER LEVINE: But… sorry, if I
5 can just interrupt but can, can, can… [cross-talk]
6 MATT SIEGLER: Of course… [cross-talk]
7 COUNCIL MEMBER LEVINE: …can you tell us
8 like what, what is the total census of beds
9 currently in H and H and, and on any given night
10 how many could we expect to be empty?
11 MATT SIEGLER: Well I think we… you know
12 you, you staff the facility to how many beds there
13 are, and some units are, are, are not actually
14 waiting to be filled beds, I can get you the
15 specific census at a… at a given time… [cross-
16 talk]
17 COUNCIL MEMBER LEVINE: Right, the
18 staffing issue is, is a separate question and, and
19 you're right to point out of course that if, if a
20 unit is on staff to at least you're not incurring
21 costs when there's no patients there… [cross-talk]
22 MATT SIEGLER: Uh-huh… [cross-talk]
23 COUNCIL MEMBER LEVINE: Does that mean
24 that you have essentially taken whole floors out
25 of use and can you… can you quantify the number of

2 units which have been essentially gone lights off
3 because of the un… because you don't have need
4 anymore?
5 MATT SIEGLER: I can certainly follow up
6 with you on that specific, I mean some of that it
7 evolves and people spread out when there is a, a…
8 space in facility, right, so we have a floor with
9 one clinical capability that could be on a smaller
10 setting if you needed it to so we're have… we're
11 looking at this across our facilities and
12 evaluating, having architects look at every floor,
13 what is the best layout and potential for how
14 things are structured so I want to make sure I
15 have good numbers for you and that we have that
16 complete analysis done which I'd be happy to
17 discuss with you…
18 COUNCIL MEMBER LEVINE: I, I, I look
19 forward to having those numbers, there's not a
20 single one of your 13 hospitals and, and dozens
21 and dozens of other facilities that isn't beloved
22 by its surrounding community and that doesn't play
23 such an important role in, in, in even the broader
24 socio, sociological and cultural life of its
25 communities. So, we, we would mourn the closing of

2 any of your facilities such… when people hear that
3 there are units which have been essentially taken
4 out of, of service because of the lack of demand
5 should we worry that then there's going to be
6 buildings closed?
7 MATT SIEGLER: No, no, no public
8 hospitals are going to be closed and I think
9 that's a… [cross-talk]
10 COUNCIL MEMBER LEVINE: Okay… [cross-
11 talk]
12 MATT SIEGLER: …thank you for, for
13 bringing that out and, and, and addressing it. I
14 think, you know it's important for our system for
15 people to understand that we have to find creative
16 ways to use space, you know a, a, a unit that is
17 not fully occupied and used does not mean that the
18 public hospital is going to be closed.
19 COUNCIL MEMBER LEVINE: And so, what,
20 what would be some of the creative ways you could
21 use that space?
22 MATT SIEGLER: Yeah, I, I think, you know
23 new models of behavioral health care, right, so
24 finding ways to treat people that gets them
25 connected back into the communities in meaningful

2 ways, you know we have extensive partnerships
3 though our performing provider system, one city
4 health with community benefit organizations that
5 provide a variety of services to people so finding
6 ways to co-locate staff like that for social
7 services to make sure people are connected into
8 those types of care, those are some things we're
9 looking at and… [cross-talk]
10 COUNCIL MEMBER LEVINE: We, we, we have a
11 shortage of, of every one of the services you
12 described particularly when it comes to serving
13 those with mental health problems, we have a
14 shortage of supportive housing, I'm not sure if
15 those facilities are candidates for something
16 permanent like that but it sounds like what you
17 might be describing is a transitional form of
18 supportive housing maybe where someone who needs
19 an intensive period of attention from medical
20 professionals while living full time could get
21 their life back together and then transition to a,
22 a less intensive setting, am, am I describing that
23 correctly?
24 MATT SIEGLER: That, that, that is one
25 model and we've, we've looked at several of our

2 facilities and have built actually supportive
3 housing and, and structures like that. As I look
4 at the CAMBA developments on Kings County, work
5 that's ongoing at Woodhull, you have to be a
6 little careful in terms of what you can build
7 inside the four walls of an inpatient facility,
8 right, you can't really have housing per se…
9 [cross-talk]
10 COUNCIL MEMBER LEVINE: Right… [cross-
11 talk]
12 MATT SIEGLER: …on a hospital floor…
13 [cross-talk]
14 COUNCIL MEMBER LEVINE: Right… [cross-
15 talk]
16 MATT SIEGLER: …but the… we have space on
17 the campuses overall and you know making sure
18 we're using all of the buildings as efficiently as
19 possible to deliver the full range of community
20 needs and supportive needs for people's health is,
21 is critical.
22 COUNCIL MEMBER LEVINE: And lastly
23 because I, I don't want to take up too much more
24 time, I've asked you about the, the implications
25 for your space of all these changes and you've

2 spoken about this in past hearings but it's
3 important to revisit, what are the implications
4 for your workforce of, of this, this changing mix
5 of services and should we anticipate additional
6 layoffs or perhaps are you actually adding staff
7 to meet need in some critical areas?
8 MATT SIEGLER: We're certainly adding
9 staff in, in some critical areas, you know primary
10 care, revenue cycle right where, where we need to
11 be a much better billing operation so there,
12 there, there do need to be significant staffing
13 increases there to make sure we're getting bills
14 out on time and doing everything we can to collect
15 revenue for the system, you know I think it's
16 about putting staff to use where the patients are
17 and where we can serve people best, right, there…
18 represented layoffs are not on the table, our goal
19 is to support our staff and you know make sure
20 we're delivering care that the communities need.
21 COUNCIL MEMBER LEVINE: Okay, so again
22 layoffs not on the table is that… [cross-talk]
23 MATT SIEGLER: Not on… [cross-talk]
24 COUNCIL MEMBER LEVINE: …what you said?
25 Okay, that's a good note to end on, thank you.

2 MATT SIEGLER: Thank you.
3 COUNCIL MEMBER LEVINE: Thank you Madame
4 Chair.
5 CHAIRPERSON RIVERA: Thank you Council
6 Member Levine. You know I just… I just wanted to
7 say we, we… in the last fiscal year I think you
8 had like a projected loss of 400 million and it
9 wasn't… it didn't end up being that you ended up
10 losing less, it was like 200 million and from what
11 I understand your deficit is two billion more or
12 less, you, you are in a… you're very financially
13 challenged Health and Hospitals is and I realize
14 that Doctor Katz is here to turn that away… turn
15 that around in ways that are very simple but it…
16 also drastic in, in, in terms of what Council
17 Member Levine mentioned and really just utilizing
18 this space but also the billing and the coding and
19 all the things that are not happening
20 administration wise and, and the reason why we're
21 so adamant about asking for the data and asking
22 for the numbers is because, you know there are big
23 changes coming to health care and it is really…
24 it… we, we know that a lot of that is on your
25 system and so we are also trying to be advocates

2 for you in terms of having a system that is
3 serving the underinsured and the uninsured and so
4 when, you know Council Members are funding things
5 like EKG machines, you know we, we really want to
6 know what's going on and why does it have to be
7 this way so I just really hope that, you know
8 going forward we, we do see some more data that is
9 very detailed and specific because if you were to
10 show us, you know the, the cancer, dental,
11 geriatric and, and the ophthalmology and the
12 services and how that has gone up over time and we
13 can say well during the same time these voluntary
14 hospitals actually closed these departments or
15 eliminated beds in this area we can start making
16 direct correlations about how we need to do better
17 in treating the public hospital system as part of
18 our general infrastructure in a… in a more serious
19 way so I just wanted to say that and I also want
20 to turn it over to my colleague, Council Member
21 Reynoso, I know he has a question for you.
22 COUNCIL MEMBER REYNOSO: Thank you Chair.
23 I won't ask as many questions as Council Member
24 Levine, I'll be more short winded. So, we can… no,
25

2 it's… we need timers, we need timers and it should
3 be no more than a minute for a mark.
4 COUNCIL MEMBER LEVINE: I, I disagree.
5 COUNCIL MEMBER REYNOSO: So, speaking of
6 the work that you're doing, I, I just want to
7 speak to the type of person that I am I guess and
8 how that plays into like the Health and Hospital
9 system, I don't have a primary care doctor when I
10 get sick or something happens I go on like a
11 website, find a doctor that can take care of me in
12 the next hour or two, pop in, pop out and just
13 keep it moving, right, I get some cold medicine or
14 whatever it is and I'm good, I don't have any long
15 term relationship with any provider so… and it's
16 about time for me, I need to be able to do these
17 things quickly because I got to get back to work,
18 sometimes I don't even miss a day of work I just
19 miss those two hours where I need to see the
20 doctor, go in and out. It seems like a part of
21 your approach is dealing with that situation and
22 knowing that you have more primary care doctors,
23 can you talk to me in two, two ways because I
24 think it's important that who you are plays out in
25 what you're doing but also that you don't cripple

2 yourself financially in trying to prove a policy
3 point here. So, can you speak to me how having
4 more primary care doctors would keep… would make
5 it so that I can go there or if it can be done in
6 the same day or next day when it comes to
7 appointments and two financially how does that
8 work in, in your modeling?
9 MATT SIEGLER: Absolutely, absolutely.
10 Well first of all I, I have our Vice President of
11 Primary Care here and… [cross-talk]
12 COUNCIL MEMBER REYNOSO: Right, I…
13 [cross-talk]
14 MATT SIEGLER: …he may just run up and…
15 [cross-talk]
16 COUNCIL MEMBER REYNOSO: I apologize…
17 [cross-talk]
18 MATT SIEGLER: …offer you a primary care
19 visit right now because he's, he's that passionate
20 about delivering care and meeting our patients
21 where they are so that's, that's one option but we
22 have better ones for you as well. It, it… as… I
23 think that's a great question and you are exactly
24 my, my target audience and target market for these
25 things, you know as part of our ambulatory care

2 transformation plan one big thing we're rolling
3 out is making sure that people have… can schedule
4 same day or next day appointments with their
5 primary care doctor now that sounds simple and
6 basic but the, the, the way that addresses both
7 parts of your question I'll get at right now.
8 First of all you want to be able to see your
9 doctor because it's… you don't want to go in and
10 explain all of your history every time to a new
11 person, right, it's an extra 15, 20 minutes of a
12 visit, you've got precious time to waste even if
13 you can schedule it somewhere else you want to go
14 into someone that knows you, knows your
15 medications, knows what you need, knows your
16 history and can really help you stay healthy that
17 makes it a worthwhile visit and not just someone
18 saying here's some cold medicine that'll be 300
19 dollars see you never, right, that's not a good
20 patient experience and not what we're focused on.
21 So, all of our scheduling systems and our
22 attribution of patients are now going to be
23 dedicated to making sure people see their one
24 primary care doctor any time they come in and the
25 way we'll accomplish that is a couple fold, one is

2 improving our data system so that we're tracking
3 this better, another is leaving 30 plus percent of
4 every physician's scheduling visits open for one
5 or two day visits so that if Council Member
6 Reynoso calls up and says, you know I'm not
7 feeling well I need a visit tomorrow you don't get
8 the answer of sorry you can see this primary care
9 doctor who you've never met before or you can see
10 your own doctor in two months, right, that's not
11 the experience you want, you want to be able to
12 deliver that same day appointment every time and
13 you know financially it… the more loyalty people
14 have to their clinicians and the more they're
15 coming in to get ahead of these health care issues
16 it, you know generates some revenue on the
17 frontend from the primary care visit, that's one
18 part of it. Really the bigger value is in our
19 risk-based contracts and in the quality
20 performance bonuses we get down the line, right,
21 if we control a patient's diabetes over time that
22 measure has a tremendous impact on what we're paid
23 by managed care plans, by the state. If we… if you
24 know to call your primary care doctor instead of
25 coming into the emergency room, avoiding that ER

2 admission can be tens of millions of dollars for
3 our system and you know that's, that's… it's
4 really critical and so those are some key ways
5 we're focusing on it so I really look forward to
6 seeing how this plays out and we, we'll get you a
7 primary care doctor at Woodhull or whenever else
8 you would like, we will… we will make it happen by
9 the end of the day if needed.
10 COUNCIL MEMBER REYNOSO: Yes, if, if
11 I'm getting an appointment… I'm going to be
12 talking to Carlina and say I… they want me to wait
13 a week cough, cough is not going to work. What…
14 [cross-talk]
15 MATT SIEGLER: Not going to happen.
16 COUNCIL MEMBER REYNOSO: So, then how
17 does… and my last question is just, the community
18 based outpatient model, right, how does that… how
19 do you… how do you benefit from that… well I guess
20 you waste less funding having to take care of
21 patients… inpatient work because that's very
22 expensive and usually not… unnecessary in some
23 cases so I guess… am I… am I understanding why an
24 outpatient model would work… community based
25 outpatient model would work even if those clients

2 are not coming to Health and Hospital… [cross-
3 talk]
4 MATT SIEGLER: Yeah, I think that…
5 COUNCIL MEMBER REYNOSO: …the city?
6 MATT SIEGLER: I think that’s one part of
7 it, right, I think the, the structure of
8 reimbursement for Health and Hospitals for
9 hospitals overall, particularly people who treat
10 Medicaid patients is changing from a model of do
11 the most, do the most expensive and intensive
12 things and we’ll pay you for it to keep people
13 healthy, keep them out of the hospitals for
14 unnecessary things and we will make you whole for
15 that and we are completely committed to that not
16 only because it’s the right thing to do
17 financially but it’s the right thing to do for our
18 patients, doctors don’t go into medicine to say
19 oh, I really want to perform invasive procedures
20 on people all the time, right, it… they do it
21 because we want to help people stay healthy and,
22 you know stay out of the hospitals which can be a
23 traumatic and difficult and sometimes dangerous
24 experience for people, right, so we… that’s the
25 reason to do it and the changing model of

2 reimbursement really can help us do that so we're
3 very focused on that.
4 COUNCIL MEMBER REYNOSO: Thank you for
5 those answers, I appreciate it and thank you
6 Chair.
7 MATT SIEGLER: Thank you.
8 CHAIRPERSON RIVERA: Be, before I turn it
9 over to Council Member Moya just a quick question,
10 how long to get an appointment at Health and
11 Hospitals?
12 MATT SIEGLER: Currently our third next
13 available appointment has come down from about 18
14 days to about 14, 13 or 14 so it's, it's an
15 improvement, you know I think the, the real
16 measure I want to see is how many unique primary
17 care patients do we have in a year, right, is that
18 number starting to climb as people feel like this
19 is a valuable and important way for me to get care
20 at Health and Hospitals and stay connected to
21 Health and Hospitals. I think that appointment
22 time number is a very good one and I want to
23 continue to see it improve but really growing the
24 base of primary care is, is a critical part of
25 that.

2 CHAIRPERSON RIVERA: Okay, Council Member
3 Moya.
4 COUNCIL MEMBER MOYA: Thank you Chair
5 Rivera. Thank you. I just have a quick question
6 and correct me if I'm wrong but didn't… when it
7 was H… HHC didn't we have community-based health
8 clinics throughout?
9 MATT SIEGLER: Correct, yep.
10 COUNCIL MEMBER MOYA: And then wound up
11 closing them because like I remember in Queens we
12 had several community based health clinics that
13 were an expansion of Elmhurst hospital in the
14 Queens health network, they had them running for
15 and operating for a number of years and then they
16 closed and the objective was the same as what
17 you're talking about now and I'm just trying to
18 figure out what, what the difference is in this
19 model that you're presenting than the model that
20 failed and closed down all the health clinics that
21 were in the surrounding areas?
22 MATT SIEGLER: Yeah… [cross-talk]
23 COUNCIL MEMBER MOYA: Maybe you can walk
24 me through that?
25

2 MATT SIEGLER: Well I… you know I, I, I
3 can't speak to the operations and structure of how
4 those were run and what the specific history was,
5 I can tell you our, our strategy going forward and
6 why we think it will work this time some of it's
7 our responsibility and… [cross-talk]
8 COUNCIL MEMBER MOYA: I get that, but I
9 think it's important to understand the difference,
10 right, I, I… [cross-talk]
11 MATT SIEGLER: Yeah… [cross-talk]
12 COUNCIL MEMBER MOYA: …hear that you're
13 telling me how we're going forward but there was
14 about six or seven in Queens and then they closed
15 so what I want to know is how is that going to be
16 different and what was the reasoning why they
17 failed or the closures, was it budget cuts, what
18 was it and how do you see this is going to be a
19 different model because everything that you're
20 saying here… [cross-talk]
21 MATT SIEGLER: Yeah… [cross-talk]
22 COUNCIL MEMBER MOYA: …is exactly what
23 was presented last time.
24 MATT SIEGLER: Okay, well I, I, I think
25 the, the key difference, there are two; one is the

2 way health care is paid for has changed and will
3 continue to evolve and that changes the financial
4 model of an outpatient-based community setting
5 like that, that's number one. The number two thing
6 is our new clinics the goal is really to have them
7 be full service clinics so we're not just pure
8 primary care, stop in and you can have a visit but
9 very little else, we'd like to include pharmacy,
10 behavioral health care, some imaging services and
11 that full scope primary care in a clinic setting
12 so it's, you know more of a holistic set of
13 services where you can come in and not just have a
14 primary care but get a series of other services
15 that make it a more valuable and, you know
16 important experience for folks so I… you know I, I
17 don't know the specific history of all of the
18 centers in Queens, I'm happy to, you know talk to…
19 [cross-talk]
20 COUNCIL MEMBER MOYA: But I, I'd love to
21 get that…
22 MATT SIEGLER: Absolutely… [cross-talk]
23 COUNCIL MEMBER MOYA: …back because
24 that's, that's, that's key and what… and, and just
25 so I'm following you, are you saying that all of

2 those services are going to be in house, they're
3 not going to be then pushed to the local hospitals
4 that are around there for… whether it's imaging
5 services or follow… or follow ups?
6 MATT SIEGLER: I get it, it depends… it's
7 a great question, it depends on the size of the
8 clinic and the, the, the proximity to a hospital,
9 right, Elmhurst has a tremendous array of services
10 that the offer and we wouldn't, wouldn't want to
11 detract from that at all, Elmhurst is a very busy
12 hospital though and I want to make sure that they
13 are doing the absolute best and highest value care
14 they can offer, right, they have the ability to do
15 amazing surgeries and, you know intensive
16 inpatient care that you could never do in an
17 outpatient setting so making sure that, you know
18 our facilities with the highest capabilities like
19 that are being used for services that can only be
20 done there and are reimbursed at that level is, is
21 important and so some services will stay in house
22 at those community centers even though hospitals
23 like Elmhurst will have those capabilities as well
24 and will be able to perform those services when
25 people arrive at Elmhurst for a primary care

2 visit. We're certainly not going to close primary
3 care at any of our hospitals, right, we'll always
4 be an option at the hospitals it's just a question
5 of do people have another setting to go to so that
6 our hospitals can be less crowded and able to
7 deliver services they only offer at hospitals.
8 COUNCIL MEMBER MOYA: Right, no I, I, I
9 understand that part what I'm saying is… what you
10 were… what you were saying that this is different
11 than what was in the past, you're describing
12 exactly what we did back then so everything that
13 you're saying we're doing differently now is what
14 they did before, right and so that's why I'm just
15 still not seeing why it's going to work now other
16 than you telling me that formulas are changing and
17 the method of which health care is paid for…
18 MATT SIEGLER: Yeah… [cross-talk]
19 COUNCIL MEMBER MOYA: …right? So, that…
20 if, if we can get back to the committee and to
21 the… to the Chair I, I think it would be very
22 helpful… [cross-talk]
23 MATT SIEGLER: Absolutely and… [cross-
24 talk]
25

COUNCIL MEMBER MOYA: …to understand that. I, I, I will say on a side note Elmhurst hospital does provide great care, my mother had surgery there on Friday, the doctors, the nurses, everyone there has been a tremendous support, I can vouch for the great work that is done in our public hospital system that you trust your mom to go there and have surgery and be well cared for. Thank you, Chairwoman, I appreciate the, the time.

MATT SIEGLER: Thank you.

CHAIRPERSON RIVERA: When someone goes into an emergency room rather than going to one of these community based clinics can they go into an emergency room be diagnosed and then see a specialist and why I'm asking is because though it may take only 14 days to get an appointment sometimes with a specialist it takes much longer so why I'm asking is while we want to encourage people to make appointments and, you know take advantage of, of the world class care that H and H provides how do we discourage or I guess motivate people to use more local care rather than going in and, and, and getting it all done in the emergency room?

2 MATT SIEGLER: Uh-huh, I, I think it,
3 it's a great point and it speaks to a, a key
4 philosophy or our primary care expansion and, and
5 this effort that's to meet people where they are,
6 right, people don't go to the emergency room for
7 no reason, they go because it's a… it's a fast way
8 to get access to certain types of care sometimes.
9 Now fast can mean waiting for five hours and then
10 getting a scan and no one… that's not the type of
11 care anyone wants to deliver. The, the key to I
12 think what you're saying also is our e-consult
13 system and so getting in to see a primary care
14 doctor whether it's same day, next day or if you
15 don't need it in 14 days, being able to get a
16 specialty visit essentially, get the opinion of a
17 specialist on your condition within a few hours or
18 a couple of days which we can do through our e-
19 consult system and we're going to scale up across
20 the entire system is critical to making that
21 experience more valuable to people because you're
22 right if it's a choice between waiting in an ED
23 for five hours to get a specialty appointment or
24 being told I'm sorry no one can see you for two
25 months in a primary care setting and another two

2 months to get a specialty visit that's, that's not
3 a hard choice, you, you, you would do the ED so
4 we've got to make it easier for folks to get the
5 care that they need in an efficient way in a
6 different setting than the ED.
7 CHAIRPERSON RIVERA: And when Council
8 Member Moya mentioned how the centers had closed
9 and not trying to repeat what is… what clearly is
10 a cycle that is… loses money, it's unproductive,
11 it's, it's, it's just inefficient how are you
12 getting the word out about the, the Gotham network
13 because, you know I, I, I mentioned that there was
14 a decline in visits, the… that… the decrease by
15 5.6 percent are you reaching out to immigrant
16 communities, are you letting them know that these
17 services exist, how are you working with community
18 based organizations?
19 MATT SIEGLER: We certainly are, we
20 certainly work through the community advisory
21 boards as well, I, I view them as a key entre into
22 the community and connection point. Council Member
23 Moya, Elmhurst is a great example of this, they do
24 a program called Walk with a Doctor and they bring
25 their doctors out into the community and you know

2 give walks with people to talk about the services
3 that Elmhurst offers, I think creative ideas like
4 that are, are critical at every institution, you
5 know we are the public system so we don't have a
6 marketing budget in a big way that we spend on
7 things like this but we do try to reach out in
8 targeted ways to communities particularly imminent
9 communities in the appropriate language and you
10 know spreading a message that we're here, we
11 welcome everybody regardless of their status,
12 their ability to pay and we have this great set of
13 services but we've got to do a much better job of,
14 of communicating that and being clear about what
15 we offer and where so I'd love to work with you on
16 that and, and spread the word around, Roberto
17 Clemente's a great idea, a great… a great example,
18 right, very connected into the community, making
19 sure the word about what they offer is available
20 everywhere and, and people know about it is a… is
21 a key priority.
22 CHAIRPERSON RIVERA: What's e-consult,
23 forgive me for… forgive my ignorance?
24 MATT SIEGLER: I'm sorry, I'm, I'm, I'm
25 so deep in the weeds here on it, it's our… it's

2 our electronic consult system so what it is, is
3 it’s the way we will do specialty referrals and
4 the system overall and what it is, is it’s a, a
5 pretty simple technical platform but you come in
6 to see a primary care doctor and the doctor says,
7 okay it sounds like you’re having, you know issues
8 with your chest let me take a listen, I’m only a
9 primary care doctor, I shouldn’t say only… I’m a
10 primary care doctor so I don’t have the ability
11 to, to diagnose exactly what that is, I’m going to
12 type up your notes, share your record with a
13 pulmonologist at a neighboring hospital, it goes
14 through essentially an email platform, the
15 specialist is able to pull it up, look at it and
16 get right back to the primary care doctor with
17 actually that’s not a serious issue, get the
18 person on this medication and if the issue doesn’t
19 resolve itself they should come in for a specialty
20 appointment in a couple of months or the clinician
21 can say okay, actually that does look serios
22 please have the person come see me tomorrow.
23 CHAIRPERSON RIVERA: And this is up and
24 running?
25

1
2 MATT SIEGLER: It's up and running and I
3 believe nine of our 11 hospitals, at least one
4 clinic right now and the goal by the end of next
5 year is to spread it much further and have it at
6 every single hospital.
7 CHAIRPERSON RIVERA: I ask because I have
8 another concern and I, I think in the future
9 we'll, we'll probably have a hearing, a joint
10 committee hearing with the Committee on Technology
11 about e-records and the implementation and it
12 hasn't been going real, really that well and you
13 know the briefing that I received has a lot of the
14 e-records kind of… the system's working in silos
15 and then not all clearly connected even across
16 the, the 11 acute facilities so how are you… in,
17 in order for the e-consult system to be successful
18 but your record systems are not talking to each
19 other how is that working?
20 MATT SIEGLER: Right now, it is working
21 separately from the individual electronic health
22 record systems, it's just a direct connection
23 between doctors and notes and clinical records can
24 pass regardless of what electronic health record
25 system each… [cross-talk]

CHAIRPERSON RIVERA: Is it email?

MATT SIEGLER: Its essentially email, yeah, it's, it's a… it's a version of that but it's a… it's a platform that lays out in a targeted way so that doctors can read and reconcile medications and look at these things, share images, x-rays, MRIs, things like that but it's… you know Doctor Katz rolled it out in LA, it reduces specialty overcrowding by 30 percent, it's going to have a critical role in our system so it's another one of these things but you're exactly right, the electronic health record systems, getting ourselves on a single clinical platform and a single financial platform is an essential goal over the next 18 months at Health and Hospitals. In the next few weeks I think October 20th, we roll out Epic which is our new electronic health record system… [cross-talk]

CHAIRPERSON RIVERA: Very exciting… [cross-talk]

MATT SIEGLER: …on the clinical and financial side at Elmhurst, Queens, Coney Island and Woodhull Hospital and a surrounding array of community facilities, you know making sure that's

2 successful and then scaling it up across our other
3 facilities throughout 2019 is absolutely essential
4 to, to that type of information sharing and being
5 an efficient and high quality system going forward
6 so you're, you're very right to point it out, it's
7 critical.
8 CHAIRPERSON RIVERA: So, in, in 2018
9 uninsured adults comprised 25 percent of H and H's
10 outpatient adult visits, do you know how that
11 compares to the amount of outpatient care that
12 other New York City hospitals are providing to the
13 uninsured?
14 MATT SIEGLER: I am certain that it is
15 higher, but I can't speak to the specifics of what
16 each individual private hospital provides.
17 CHAIRPERSON RIVERA: I'm going to write
18 down high up. Okay, so I'm going to ask Greater
19 New York, when they testify I'm going to ask them,
20 you know in terms of how they provide… you know
21 services to uninsured, underinsured, immigrant
22 communities and see if they have some numbers for
23 me and I hope that, you know again next time we
24 can talk a little bit more math…
25

2 MATT SIEGLER: I, I, I apologize I… just
3 off the top of my head I'm happy to share some
4 general numbers with you. So, you know our
5 uninsured hospitalizations in… were 35 percent of
6 the uninsured visits in New York City, our
7 emergency visits were 49 percent of the uninsured
8 visits in the city and our clinic visits by some
9 measures the… were 71 percent of the uninsured
10 visits in New York City so those are… those are
11 numbers from our… from our system and the hospital
12 cost reports of 2015, you know we… it's, it's a
13 critical part of what we do, it's, you know a
14 number we focus on to make sure we're getting
15 everybody who's eligible insured that's an, an
16 important effort. You've heard Doctor Katz talk
17 about it and one we've been focused on and are
18 starting to see some success on, making sure we
19 sign up eligible people because sometimes if you
20 don't ask people to sign up or you don't make sure
21 they know what they're eligible for, you know they
22 won't… they won't sign up and it will be an
23 uninsured visit so we've got to… we've got to get
24 better about that on our financial system but it
25 is a critical part of our mission so… [cross-talk]

2 CHAIRPERSON RIVERA: Okay, can you just
3 say that again because that… you should have put
4 that in your testimony, I think those numbers are
5 very, very important but, but I'm not running the
6 show there, can you… you said in 2015, can you,
7 you said H and H provided in terms of uninsured
8 New Yorkers probably up to 71 percent of clinic
9 visits?
10 MATT SIEGLER: The market share of
11 uninsured visits at the clinic level, yes.
12 CHAIRPERSON RIVERA: And then 49 percent…
13 MATT SIEGLER: 49 percent of the
14 emergency visits for uninsured.
15 CHAIRPERSON RIVERA: Did you say
16 something else or was those, those the only stats
17 you had?
18 MATT SIEGLER: Inpatient hospitalizations
19 35 percent.
20 CHAIRPERSON RIVERA: Okay. Okay and I'm
21 not sure if any of the other… Council, Council
22 Member Ayala.
23 COUNCIL MEMBER AYALA: So, is there a
24 mechanism that H and H uses to track the
25 effectiveness of ambulatory care for patients that

2 just receive… you know had a procedure done and
3 was sent home?
4 MATT SIEGLER: Yes, absolutely, we, we
5 track clinical quality measures across the board,
6 we have a care management program that follows
7 people after they receive care at our facilities
8 particularly if they've been high utilizers of
9 care in a lot of different settings and we try
10 our, our best to track that. As the Chair pointed
11 out the electronic health record systems we have
12 and our internal data capabilities make that a
13 challenge but it's a key focus of ours to track
14 people after they leave the hospital, make sure
15 we're following up with them and preventing them
16 from coming back to the hospital if they don't
17 need to, we want to make sure that we follow up
18 with people in the efficient way and get them into
19 primary care to stay healthy and stay out of the
20 hospital.
21 COUNCIL MEMBER AYALA: And what is that
22 tracking data suggesting, are we on the right path
23 in terms of, you know the way that we're
24 approaching clinical care, or, or have there been
25 complications, I mean I, I mention it because I

2 had a… three years ago I think or so I had my
3 thyroid removed and you know even for, for me, you
4 know I'm, I'm busy as, as Antonio mentioned and
5 not necessarily taking the best care of myself and
6 I need… you know I have a nodule, I have to have
7 biopsies, get my thyroid removed, I study it, I
8 research it, I hear I may have to spend the night
9 because I'm having the whole gland removed and
10 then I get there and they're like you're going
11 home today and I felt like I was dying and I
12 didn't understand why I was being sent home and I
13 hear this a lot from my constituents who feel like
14 they're being rushed out of the hospital before
15 they feel mentally prepared so is there some sort
16 of like maybe campaign that better educates
17 patients on, you know what the new processes and
18 why, you know certain, you know procedures require
19 that individuals now, you know go home the same
20 day and follow up, you know later?
21 MATT SIEGLER: Uh-huh, yeah well we have…
22 it's an important thing in making sure patients
23 understand the instructions they're being given
24 and the course of their treatment is a critical
25 issue for all hospitals and I think something

2 American healthcare generally does not do that
3 well at, right, it… you can forget that it's a
4 scary place to be when you're in a hospital,
5 right, people… it's… you… clinicians and
6 administrators can forget that anytime someone's
7 in a hospital it's potentially one of the scariest
8 days of their lives and we have to be sensitive to
9 that and make sure we're paying very close
10 attention and communicating clearly and slowly
11 with folks and making sure they have the time to
12 ask the questions they need to ask. So, you know I
13 think a, a way we really focus on it is we have
14 extensive social work departments that work in
15 discharge planning at all of our hospitals, that
16 care management function is something that we are
17 investing in and need to focus more on and make
18 sure we're doing good follow up care for people
19 but I, I completely take your point, it's a… it's
20 a challenge across the health care industry and
21 something that I know we need to do better at.
22 COUNCIL MEMBER AYALA: Yeah, I, I, I
23 agree and I want to thank the nurses because they,
24 they are often times on the front line and, you
25 know have to deal with patients like myself who

2 are a little bit confused and maybe still sedated
3 and being sent home crying but last question
4 regarding the current financial issues that HHC is
5 facing. Does HHC currently have a list of
6 properties that may be underutilized that could be
7 used as a mechanism to… for generating revenue in
8 the future that you would be able to provide to
9 this council?
10 MATT SIEGLER: I'm happy to discuss it,
11 yeah, I think our, our, our footprint of
12 facilities is, is certainly public record and
13 happy to get into more details and, and talk more
14 about specific… [cross-talk]
15 COUNCIL MEMBER AYALA: Yeah, I'm
16 specifically… [cross-talk]
17 MATT SIEGLER: …properties… [cross-talk]
18 COUNCIL MEMBER AYALA: …interested in
19 like properties that are like underutilized right
20 now, we had for example in East Harlem we had the
21 Draper Hall facility that was current… it was
22 being used at some point for housing for nurses
23 and then after Sandy the building, you know
24 underwent massive flooding, there was mold and
25 mildew and couldn't be used and then at some point

2 was transferred over to a private developer for
3 100 percent affordable housing which I'm really
4 excited about because we desperately needed that
5 but I also saw it as a, understanding the finances
6 of Metropolitan Hospital and how important it is
7 in my community to keep that hospital there and
8 readily available to provide services to the
9 underserved and to the uninsured why the hospital…
10 why HHC kind of missed the opportunity to also
11 because there was an adjacent property, to develop
12 it in a way that would generate revenue for years
13 to come. We have another property that's also I
14 think three parcels, two of them which are owned
15 by the city, HHC, right now across the street from
16 the same hospital where sanitation is housed,
17 sanitation is… we're in… we're in conversations to
18 move that garage to another part of the district
19 and that means that that, that property will be
20 vacant at some point and I wondered if there's any
21 future… if there's any conversations about the
22 future of that property and how is HHC really
23 prioritizing these, these, you know vacant… these
24 opportunities, right… [cross-talk]
25 MATT SIEGLER: Yeah… [cross-talk]

COUNCIL MEMBER AYALA: …to, to create just further revenue?

MATT SIEGLER: Well we'd, we'd, we'd love the opportunity to work with you on it, I think you're, you're… it's a… it's a critical point, we need to use all of our land and structure to advance the cause of the public health system and that's providing patient care, that's providing housing options and community benefits in the area and it's generating revenue, all of those things make the health system more sustainable and can help improve the health of the community so we'd love to work with you on that and… [cross-talk]

COUNCIL MEMBER AYALA: So, we can expect to see the list?

MATT SIEGLER: Happy to.

COUNCIL MEMBER AYALA: Thank you.

CHAIRPERSON RIVERA: So, we've been joined by Council Member Eugene. I wanted to ask about something that Council Member Ayala brought up that I think a lot of people wonder about in terms of how you spend so much less time in a hospital which is as you mentioned a benefit in terms of getting better at home and you're less at

2 risk to get ill or, or exacerbate whatever
3 symptoms you have but is there a financial
4 incentive to release people the same day in terms
5 of how you're reimbursed?
6 MATT SIEGLER: In, in some cases there,
7 there may be. The, the… you know there is a big
8 financial incentive I will say though for
9 preventing readmissions, right, so some hospitals
10 have to… do have to strike that balance and making
11 sure you're not keeping people longer than an
12 insurance company will pay for, we certainly
13 struggle with that, right, someone is admitted for
14 a day or two and if they stay a third day, whoop,
15 no payment for that, you can only get paid for the
16 first two so that is an incentive for some
17 institutions, you know I think a, a key thing
18 though is that readmissions question, if you send
19 someone home too soon and then they're back within
20 30 days, you know hospitals are rightly penalized
21 for that and we need to do a better job of making
22 sure we're preventing those unnecessary
23 readmissions in providing, you know holistic care
24 along the continuum.
25

2 CHAIRPERSON RIVERA: Are people who
3 aren't admitted provided with discharge planning?
4 MATT SIEGLER: They are. Observation
5 status might be what you're… what you're talking
6 about or people coming out of the ED, we try to do
7 100 percent discharge planning as people leave the
8 ED, emergency department, our emergency
9 departments are some of the busiest in the whole
10 country but it is a, a, a critical issue to make
11 sure that we're following up with everybody as
12 they leave to make sure they understand the course
13 of care afterwards, understand you should come
14 back in a for a primary care specialty appointment
15 in X number of days, the ED is a critical
16 opportunity to do that for people as they're
17 leaving from there but given, you know the, the
18 volume of people the ability to do, you know
19 intensive personal discharge planning like that
20 is, is a struggle but something we've got to get
21 better at.
22 CHAIRPERSON RIVERA: So, I, I have one
23 more question because I do know that there are
24 advocates here to testify and I want to thank them
25 all for their patience and of course Greater New

2 York is here to testify as well and it's… and it's
3 about something I mentioned in my testimony which
4 is DSRIP and so how is Health and Hospitals
5 involved in the DSRIP program?
6 MATT SIEGLER: So, we… thank you for that
7 question, so it's an important program that's
8 changing the way health care is reimbursed in the
9 state, Health and Hospitals is the largest partner
10 of the largest performing provider system in the
11 district program, it's called One City Health,
12 we're one of 169 community partners that are a
13 part of this PPS and so we work together as a
14 group to make sure we're improving the health
15 outcomes of the patients who are attributed to the
16 system and reducing unnecessary hospitalizations
17 and hospital use across all of the different
18 partners in the PPS so we're very involved and
19 committed to it.
20 CHAIRPERSON RIVERA: Well what CBOs do
21 you work with, what's the relationship like?
22 MATT SIEGLER: So, we work with a variety
23 of CBOs across, across the city and across
24 different services. As I said there are, you know
25 169 from housing providers to people who come into

2 homes to check on people's asthma and make sure
3 that there's not a lot of dust or allergens that,
4 that aggravate things, there are food delivery
5 services that are part of the partnerships, so
6 it's a wide variety and the One City team meets
7 with those partners on a monthly or more frequent
8 basis to make sure we're working effectively and
9 efficiently together but I think, you know
10 increasing that partnership, improving the
11 communication and the… is, is a critical priority
12 as, as DSRIP continues.
13 CHAIRPERSON RIVERA: Have you got any
14 feedback from the CBOs about how you engage with
15 them?
16 MATT SIEGLER: I think, you know a, a key
17 lesson I've learned from Doctor Katz and in other
18 settings is you can never engage too much, it's
19 always a good thing to be more connected to these
20 community groups and to everybody that you're
21 working with, the more communication you have the
22 better understanding of what each side needs so I
23 think there has been some desire for, for more
24 communication and you know more transparency on
25 how the flow of funds from the state through the

2 PPS to the different community groups is working
3 and I know our CEO of One City and his team are
4 doing a tremendous job of, of improving that and
5 making sure we're as engaged as possible with
6 those community groups.
7 CHAIRPERSON RIVERA: And how might the
8 potential dissolution of the DSRIP program affect
9 the financial operations of H and H in the larger
10 New York City hospital community?
11 MATT SIEGLER: Yeah, well I think it's,
12 it's, it's critical that policies that reward
13 value based care that encourage health systems to
14 be more efficient in how they're delivering
15 services continue, what form that takes is, you
16 know above my pay grade and a state policy issue
17 but one that Health and Hospitals will focus on
18 intently and, and cares a lot about so our, our
19 focus is on making sure that policies like that
20 continue so that we can continue doing the value
21 based care, community based care that is best for
22 people's health rather than going back to fee per
23 service system where we're competing on, you know
24 delivering the most and most expensive services,
25

2 it’s critical to keep policies like that
3 continuing.
4 CHAIRPERSON RIVERA: Well I want to thank
5 you. I, I want to just stress again what a lot of
6 my Council Members said which is, you know
7 educating consumers and I, I know you’re a bit
8 strapped for cash but I really want you to
9 consider us advocates for H and H considering how
10 much you have to take on in terms of serving
11 underinsured, uninsured patients, our immigrant
12 community and how the transition or I guess the
13 transformation of health care in the city
14 specifically at some of the voluntary hospitals
15 looks a very different way from your
16 transformation so that’s… you know that’s why we
17 are just so… we are going to be really just
18 adamant about getting the numbers, the data and
19 again our, our funding of simple things that we
20 feel should be something that you have an
21 abundance of really just causes us to pause a
22 little bit and ask, you know in terms of financial
23 management, in terms of how you are, you know
24 pushing people to the Gotham Network to get that
25 primary care by, by someone who’s going to get to

2 know them and their family is really important but
3 you know we're only as good as the information
4 that we have and so I'm, I'm just going to ask
5 again and I'll ask you every single hearing, I'm
6 going to say it every time in terms of the
7 transparency of, of, of the data and the numbers
8 and the financials, you know that's how we can
9 hold each other accountable. So, I want to thank
10 you, I, I do encourage you to remain for, for the
11 rest of the hearing to hear from the advocates and
12 to hear from some of the people here and we look
13 forward to some of the information that you
14 promised to my colleagues and we'll follow up with
15 any additional questions.
16 MATT SIEGLER: Absolutely. If I could
17 make one other pitch for you, you reminded me of
18 one thing. It is open enrollment right now for all
19 city employees, Metro Plus is my health plan, it's
20 a health plan owned by Health and Hospital, one
21 way the council and everybody, you know can help
22 is if, if you want to sign up for Metro Plus this
23 year, it could be great for your health, for the
24 health of Health and Hospitals and we'd be happy
25 to connect you to any physicians in their network

2 including Doctor Katz or Doctor Long or any of the
3 great folks in our system so that's my one final
4 pitch and I apologize for stealing the last word
5 but…
6 CHAIRPERSON RIVERA: I'm going to have
7 the last word… [cross-talk]
8 MATT SIEGLER: Okay… [cross-talk]
9 CHAIRPERSON RIVERA: …I'm going to ask
10 you to check out the off Ed that Council Member
11 Levine and I wrote about this very topic in Gotham
12 Gazette, thank you.
13 MATT SIEGLER: Absolutely, thank you…
14 [cross-talk]
15 CHAIRPERSON RIVERA: Thank you so much to
16 both of you. I wanted to call up David Rich from
17 the Greater New York Hospital Association.
18 [off mic dialogue]
19 DAVID RICH: There we go, I think I have
20 to call Doctor Katz for an appointment right this
21 moment. Thank you so much for having me this
22 afternoon, my name is David Rich and I'm an
23 Executive Vice President at the Greater New York
24 Hospital Association. As many of you know Greater
25 New York's membership proudly includes all of the

2 hospitals in New York City including the public
3 hospitals and all of the voluntary hospitals as
4 well as hospitals throughout New York State, New
5 Jersey, Rhode Island and Connecticut. I'm pleased
6 to be here today to discuss the transformation of
7 hospitals in New York City and the strong actions
8 hospitals have taken to enhance the accessibility
9 and quality of care provided to the communities
10 they serve outside of the four walls of the
11 hospitals. But make no mistake, there is no
12 substitute for the inpatient, acute, highly
13 specialized surfaces… services hospitals provide.
14 Unique among health care providers, hospitals are
15 available 24 hours per day, 365 days per year in
16 the times of New Yorker's greatest need and Chair
17 Rivera thank you so much for your words earlier
18 today about first responders and about Bellevue
19 being there for the people who were harmed by the
20 fire this morning, our sympathies go out to
21 everyone who was involved but that's what really
22 constituents expect hospitals to do and to be and
23 to be there for them, to provide those acute care
24 services in times of emergency and in times in
25 need and so it's very important I think. So, often

2 people say shouldn't hospitals do more and yes
3 they should and shouldn't hospitals be doing this
4 that and the other and yes they should but this is
5 something that I think is always critical to
6 understand that when constituents think of
7 hospitals and their time of need and when they're
8 brought by an… they're in an emergency and brought
9 by ambulance it's really sort of the, the part…
10 the, the types of services only hospitals provide
11 are the ones that they're thinking of. Having said
12 that, hospitals are much more than providers of
13 inpatient care as you know. They are community-
14 based providers. This has always been the case, as
15 many of our hospitals have traditionally been the
16 primary and specialty care providers for their
17 communities typically in… typically in areas of
18 the city where access to private physician's
19 offices have always been limited. Our hospitals
20 have maintained major ambulatory care networks
21 with a focus on providing care to the Medicaid
22 population and to other vulnerable New Yorkers.
23 So, often traditionally we've seen hospital
24 clinics in inner city areas really be the only
25 place that people have been able to get outpatient

2 care because there are not that many private
3 physician offices. Those… that care has often been
4 provided in those clinics with the help of
5 residents which is not always the best way of
6 providing health care and as I'll mention in a few
7 moments we're trying to change that over time so
8 that that care can be provided in different ways.
9 We are however in the midst of a nationwide
10 revolution in health care delivery and I think
11 it's important to understand when we're looking at
12 what's happening in New York City this really is a
13 nationwide change and revolution that we're seeing
14 in health care delivery. These changes began
15 before President Obama's affordable care act
16 became law in 2010. Hospitals across, across the
17 country have for years been encouraged to
18 integrate partner, partnering with and often
19 actually merging with other hospitals as well as
20 integrating with other provider types such as
21 physician groups, clinics and long-term care
22 providers such as nursing homes and home health
23 care agencies. The integration has been encouraged
24 by federal and state policy makers who as you know
25 regulate the hospitals very heavily for three

2 reasons; first, although I don't think this is the
3 most important reason but the first is efficiency.
4 Public insurers like Medicaid and Medicare have
5 reduced payments to hospitals creating financial
6 strain for hospitals especially those that rely on
7 those public programs for a majority of their
8 revenues and we just obviously heard terrific
9 testimony from Mr. Siegler about some of the
10 struggles safety net hospitals have because of the
11 fact that they are mainly funded by Medicare and
12 Medicaid. Federal and state authorities are
13 demanding that hospitals do more with less and in
14 addition care that once was provided only in
15 inpatient settings has due to new and innovative
16 treatments and technologies move outside of the
17 hospital at a time when hospitals are also being
18 incentivized to reduce unnecessary hospital
19 admissions. This means less demand for inpatient
20 beds and creates empty, underused and therefor
21 often inefficient units because actually when the
22 units are empty they still end up being heated
23 somewhat, there still are capital costs that go
24 into the fact that they are empty and so there is
25 an inefficiency just in the fact that they are

2 still there. To address this federal and state
3 authorities have urged hospitals to collaborate
4 and often to merge so they can reduce costs and
5 enhance quality. Second and most important reason
6 that the federal government and the state have
7 encouraged these consolidations is access.
8 Financially sound institutions have often been
9 asked and in some cases required by federal and
10 state authorities to merge with financially
11 challenged institutions or to transform health
12 care delivery at a particular site to ensure that
13 communities, communities continue to have access
14 to health care. Hospital mergers provide
15 efficiencies thus preserving access but also make
16 resources available to the previously financially
17 challenged institution through investments by the
18 financially sound partner and critically
19 government. In New York State, the Cuomo
20 administration and your colleagues in the state
21 legislature have provided much needed operating
22 capital funding to help such mergers and
23 transformations take place over the last few
24 years. Now it’s important to point out the goal of
25 all of this activity is to… is to preserve access

and quality for communities which without a merger or a transformation of a service were facing the prospect of hospital closure and the complete loss of health care services and unfortunately before we saw some of this planning done several years ago a lot of hospitals just closed without any sense of what was going to come next and I think what we've been trying to do in the state of New York over the last few years is to do things in a much more planful way with new partners who can come in and try and help manage the situation. It is important in these situations for hospitals, policy makers and elected officials alike to understand the dynamics that necessitate change, to properly and fully include communities and to educate communities and patients about why change is necessary, how quality will be enhanced and critically how care will be accessed during and after the transformation. You talked a lot about transformation today Chair Rivera and I think those… that communication is extremely important. It's also critically important that hospitals engage their workforce. The third reason we've seen a lot of this encouragement by its… the feds

2 and by the state, is that hospitals are being
3 encouraged to integrate with other providers to
4 enhance quality. As the fed… at the federal and
5 state level, policy makers have urged hospitals to
6 work together inside and outside the hospital to
7 reduce unnecessarily and costly readmissions to
8 hospitals but also to prevent unnecessary
9 hospitalizations before they even happen. Policy
10 makers have increasingly required hospitals to
11 take responsibility for care provided outside the
12 four walls of the hospital and this has meant that
13 hospitals must acquire physician practices and
14 partner with free standing clinics, other
15 community-based organizations, nursing homes and
16 home health care agencies. Now while these trends
17 began before federal health reform was enacted,
18 the ACA greatly accelerated these trends by
19 profoundly changing how the Medicare program pays
20 hospitals with the goal of enhancing quality and
21 efficiency. The… in my written testimony I go
22 through a lot more detail than all of this, I'm
23 promise I'm not reading the whole nine page
24 testimony but I'll just mention a couple of them
25 and there's a lot more detail and I'm more than

2 happy to answer questions about them as we go
3 along but these Medicare changes include Medicare
4 value based purchasing, which Mr. Siegler talked a
5 little bit about earlier, readmissions penalties,
6 health information technology incentives but also
7 penalties for lack of communication across
8 different providers, encouraging the, the creation
9 of accountable care organizations, enhanced…
10 advanced health community models and also changing
11 the way hospitals and other providers are
12 reimbursed through what are called bundled
13 payments. Now starting in 2011, New York State
14 responded to these profound changes, changes and
15 took them a step even further by initiating major
16 Medicaid reforms designed to improve quality and
17 efficiency with a major emphasis on care
18 management for all Medicaid beneficiaries. Later,
19 as a condition of participation in the state
20 Medicaid waiver known as the delivery system
21 reform incentive payment program or DSRIP as you
22 mentioned earlier, hospitals and other providers
23 are required to create large collaboration,
24 collaborative groupings known as preferred
25 provider… I'm sorry, performing provider systems

2 or PPSs. Nearly all of the hospitals in New York
3 City are participating in DSRIP as you heard from
4 Mr. Siegler before, H and H is a very strong
5 participant, either is PPS heads as members of
6 PPS's are both and they are required as a part of
7 this program to do a huge amount with other
8 providers to prevent hospital readmissions,
9 prevent emergency room visits, enhance primary
10 care access, properly manage behavioral health,
11 screen for diabetes, and on and on and on and in
12 my written testimony I go through a lot of the… a
13 lot of the examples of what DSRIP requires and the
14 primary goal of all of it is to reduce hospital
15 use by 25 percent over five years by the Medicaid
16 population. So, as you can hear we hear over and
17 over again whether it's the federal government,
18 the state government, Medicare incentives,
19 Medicaid incentives, all of the incentives are for
20 hospitals to work to actually keep people from
21 coming to them at least on the inpatient side and
22 the way to do that is to do more on the outpatient
23 side and to partner a lot more with outpatient
24 providers and also community based organizations
25 who help work on the social determinates of

2 health. We've seen hospitals get much more
3 involved with community-based providers both
4 through DSRIP but also on their own to develop
5 programs and partnerships with, with schools, to
6 improve housing quality so that people can stay in
7 their homes, so that they don't have readmissions
8 to the hospital, etcetera, etcetera.
9 CHAIRPERSON RIVERA: So, Mr. Rich if you…
10 [cross-talk]
11 DAVID RICH: Yes…
12 CHAIRPERSON RIVERA: …wrap, wrap up I'd
13 love to ask you some… [cross-talk]
14 DAVID RICH: Yeah… [cross-talk]
15 CHAIRPERSON RIVERA: …questions… [cross-
16 talk]
17 DAVID RICH: Yes, absolutely… [cross-
18 talk]
19 CHAIRPERSON RIVERA: …if we can get to
20 them, yeah… [cross-talk]
21 DAVID RICH: Just a couple of things
22 really quickly. I do in the written testimony talk
23 about what DOH has found has been some of the
24 quality outcomes of DSRIP. I don't think it's
25 DSRIP alone because as you've heard all of the

2 trends from the federal government as well as from
3 the state are to try an reduce hospital admissions
4 and readmissions but earlier this year DOH
5 reported that preventable readmissions have
6 declined by 15.2 percent, preventable emergency
7 room visits have declined by 14.3 percent and
8 behavioral health preventable emergency room
9 visits have declined as well. And just lastly, I
10 know a lot of questions have been raised over time
11 about, with all this transformation going on and
12 all the changes going on and additions of
13 services, subtractions of services, movement of
14 services, how is all of that regulated and how…
15 what is the oversight? As you know the oversight
16 is at the state level, it's done through the State
17 Department of Health. Your colleagues in the state
18 senate and the state assembly, through the public
19 health law have vested that responsibility in the
20 State Department of Health and also with the
21 Public Health and Health Planning Council, which I
22 know you're familiar with as well. Not all service
23 changes have to go through that public process as
24 you know but I do think that we have found that
25 DOH does… they have… they're extremely committed

2 people who are trying very hard to make sure that
3 before there's an approval of a service change
4 that they understand what some of the access
5 changes might be and they have disapproved many
6 applications when they have been concerned about
7 what access will look like after the change is
8 made. Anyway, with that I went on way too long, so
9 I will stop… [cross-talk]
10 CHAIRPERSON RIVERA: Okay… [cross-talk]
11 DAVID RICH: …there, thank you… [cross-
12 talk]
13 CHAIRPERSON RIVERA: …I should of…
14 [cross-talk]
15 DAVID RICH: …again for having me.
16 CHAIRPERSON RIVERA: No, thank you so
17 much for your testimony and I'll… I should have
18 warned you there was a clock but it's okay. So, I
19 want to… I have a couple of questions that I did
20 ask of H and H that, that I'll somewhat repeat,
21 and you were clearly here for the entirety of
22 their testimony from what I saw…
23 DAVID RICH: Yes… [cross-talk]
24 CHAIRPERSON RIVERA: So, thank you for
25 your patience. And they said a couple of things

2 that I'd love for you to address, you know
3 directly but before we do that, you know there's a
4 lot of discussion on costs and where you go to
5 receive care and how much it will cost you and the
6 differences in networks…
7 DAVID RICH: Yes…
8 CHAIRPERSON RIVERA: And so, with certain
9 hospitals having largely different costs in
10 providing care to patients, how do we encourage
11 patients to utilize services and networks in a way
12 that doesn't saddle lower cost networks with one…
13 unrealistic patient populations like how are you
14 going about working to ensure that people are
15 utilizing networks equally and that there aren't
16 certain networks that are being, again saddled
17 with more of the, you know certain kinds of care,
18 uninsured and underinsured population? My question
19 really centers around equity, you know and making
20 sure that that, that there isn't, you know this
21 hospital that certain people don't go to and that
22 hospital and, and how are you ensuring that, that
23 populations are, are served equally?
24 DAVID RICH: That's a really good
25 question and I think, you know in the current

1
2 system that we have a lot of it depends on the
3 insurer and the insure network that they have
4 negotiated with different providers and that's
5 even true within the Medicaid population because
6 as you know almost all of Medicaid now is Medicaid
7 managed care, there are different Medicaid managed
8 care providers, Metro Plus obviously is a huge
9 one, Health First is another and they have
10 contracts with hospitals for in network care and
11 then other hospitals or other providers are out of
12 network. On… when it comes to Medicaid being in
13 and out of network because there are very strong
14 rules about not having out of pocket costs, it's
15 not as… it's not quite as noticeable but when it
16 comes to the non-Medicaid population it can be
17 quite a difference. If you have insurance that
18 allows… and you have a hospital that's in network
19 and you go to one that's out of network the cost
20 could be much higher for you because you went to
21 an out of network hospital as opposed to an in
22 network hospital but that will depend largely on
23 the insurance that you have and which hospitals
24 they have actually negotiated, negotiated with.
25 Now nearly all, if not all of the hospitals in New

2 York City are in Medicaid managed care networks,
3 many of them and many of… you know many of them
4 have their own as does Metro Plus as was mentioned
5 by H and H, others are, are partners in Health
6 First for instance, there are about 10 or 12
7 voluntary hospitals that are a part of that
8 network as well so on the Medicaid side for the
9 most part there should be access to hospitals
10 through their Medicaid managed care plans and they
11 should not be out of network.
12 CHAIRPERSON RIVERA: You know in their
13 testimony… H and H takes everyone, you know
14 regardless of status, of, of language they take
15 every single person and, and, and for that I think
16 is a lot of why besides some inefficiencies in, in
17 some administrative capacities but I think that's
18 a large reason why and even in my own district
19 when you walk along First Avenue there is a lot of
20 talk on, you know which people go to NYU versus
21 which people go across the street to Bellevue,
22 it's just something that happens all the time,
23 this is a common conversation… [cross-talk]
24 DAVID RICH: Uh-huh… [cross-talk]
25

CHAIRPERSON RIVERA: …that if you are poor, under, underinsured, uninsured, you're an immigrant, you speak English as a second language you go into Bellevue and, and certain private hospitals aren't as welcoming and in fact in H and H's testimony they said many hospitals continue to compete for patients and base their business models on offering expensive tests, consultations with specialists and elective procedures that may not deliver true value to the patient or the taxpayers, do you agree with that statement, do you feel like that your network is, is providing true value to patients?

DAVID RICH: Well just to remind you H and H is also a member of ours so we definitely always make sure to say that we agree with them but yes, I think… you know that is something that I think Mr. Siegler talked about that we're trying to move away from and it really is something that needs to be moved away from and whether we want to move away from it or not it's happening because not only the Medicare program as I mentioned is not going to pay anymore for every single test you do or for every single procedure that you provide,

2 the Medicaid program is not going to do that
3 either and neither are, are private insurers and
4 so what we see and this is laid out somewhat in
5 the written testimony as well, what we see is
6 moving from paying everyone for the most expensive
7 thing, the most expensive test and paying someone
8 for every single person who comes into the room to
9 see the patient separately we're moving to sort of
10 one payment for an entire episode of care for
11 instance. So, if someone comes right before they
12 come to the hospital until a while after they've
13 left, there may be one payment for everything and
14 what that encourages is not doing everything
15 necessarily, not doing unnecessary things, you
16 need to still do the necessary things and what
17 usually payers do and certainly Medicare does this
18 when they have these types of payment arrangements
19 is they require quality reporting to make sure
20 that you are actually doing what you need to be
21 doing and you're doing enough but the idea behind
22 a bundled payment and behind those types of
23 payments is to try and make sure that all the
24 providers are working together to provide the best
25 care and also the most efficient care because if

2 at the end of the day you provided the most
3 efficient care then there might be some savings
4 left over to reinvest in care for others who might
5 need more and who've… for instance the payment is
6 not enough for the care for that patients. So, I
7 think… you know we certainly agree that that is
8 something that we're moving away from and I think
9 we're only going to see an acceleration of the
10 move away from that type of payment model and that
11 type of behavior.
12 CHAIRPERSON RIVERA: You, you don't…
13 mention in your testimony some of the, I guess the
14 hospitals in your network and I realize there is a
15 mix, can you speak to hospitals that… I guess that
16 you're representing in many ways, hospital
17 networks that have changed recently that is… that
18 have been consolidated with another entity?
19 DAVID RICH: So, you know as I mentioned
20 we have as members every hospital in New York City
21 and there has been a huge amount of that activity…
22 of network activity if you will, a huge amount and
23 as I mentioned in my testimony some of this is, is
24 very much encouraged by the federal and the state
25 government particularly when it had to do with a,

2 a more financially sound hospital partnering with
3 one that was not financially sound but also just
4 on their own a number of hospital networks have
5 been growing and have added more hospitals to
6 their networks. This is a nationwide trend and
7 actually New York has been somewhat behind that
8 trend. You see in other parts of the country
9 hospital chains of, you know hundreds of hospitals
10 which you don’t see in New York State, part of why
11 you don’t see that is that we don’t have for
12 profit hospitals in New York State, we have a
13 prohibition against publicly traded hospitals in
14 New York State as they don’t have a prohibition I
15 don’t think in any other state and that’s part of
16 why you’ve seen those huge hospital systems build
17 up in other states but you’ve seen a lot of… a lot
18 of consolidation and a lot of network activity and
19 a lot of it has to do with what I said before
20 which is trying to create better efficiencies. If
21 you think of when… of hospital care in the past
22 when someone went… you know needed a knee
23 replacement for instance they could be in the
24 hospital for several days now it’s an outpatient
25 procedure. There were times… there are some

2 cardiac procedures which you used be in the
3 hospital for several days for and now they're
4 outpatient procedures. So, there are
5 inefficiencies from the standpoint of a large… you
6 know as doctors have said before, a large, huge
7 building that might have empty units, empty wards
8 in it and that has driven some of the… some of the
9 need for combining and collaborating that we've
10 seen not only in New York City but really across
11 the country.
12 CHAIRPERSON RIVERA: So, in your
13 testimony you… towards the end and, and we
14 couldn't get to all 12 pages but the… you had the
15 certificate of need process and you mentioned
16 DOH's role and how you feel like people look at it
17 with a… you know a, a, a lens that is I guess
18 beneficial in some ways but I, I want to ask about
19 the certificate of need process and I want to ask
20 how have your members engaged communities that are
21 impacted by hospital consolidations and are forced
22 to go through this process because many of the
23 people that I speak to feel like the certificate
24 of need process be, besides trying to demystify it
25 or explain it that it isn't really inclusive and

2 it doesn’t really engage communities and so in
3 fact that there are many ways to take the process
4 and kind of, you know manage it in a way that’s
5 beneficial to what some people feel are unneeded
6 consolidations or unwanted consolidations in their
7 communities so can you talk to me about how have
8 your members engaged communities and what feedback
9 have you received from stakeholders about the
10 process itself in terms of hospitals that have
11 gone through it?
12 DAVID RICH: Sure, absolutely and I
13 would… we would be the first to say it’s a very
14 complicated process and it is a very long process
15 for both the hospitals going through it and also
16 for other stakeholders who are interested in it.
17 It is a state process as mentioned because it
18 comes out of state public health law which is… you
19 know it’s the state that licenses hospitals and
20 all other health care providers and so they are
21 the ones who have the responsibility for this. As
22 shown in the chart in the testimony there are
23 certain types of changes, additions, mergers, new
24 providers cropping up that do require sort of full
25 review and public review and public hearings

before the public health and Health Planning Council. I did mention in there that reduction in services are not always required to have that kind of full PHHPC review and that is something that a lot of questions have been asked about. From my experience and from what I understand and in talking to our hospitals and what we'd certainly think a best… is a best practice is that we think the hospitals need to be early and often meeting with their community boards not just the community boards though, you are on a community advisory board I know and that is as inclusive as it can be but there are others too who have interest and have concerns but also with other community groups, they should certainly be meeting early and often with their state legislators, with their city council people and the hope would be… I mean these are… these changes are very complicated and I think your first question of the day was a very important one, which is why is outpatient care necessarily better and that's a question that most people on the street would not… well they might not know to ask it first of all but they would not really, you know understand it. As I said before

2 when people think of hospitals they think of, you
3 know shows like ER and 9-1-1 and, and also their
4 own… their own perception of what… you know when
5 they've needed it or when their parents have
6 needed it, they think of inpatient care. And so…
7 and so, it's always a difficult discussion when
8 it's deemed necessary by policy makers, a
9 hospital, and other providers to downsize
10 inpatient capacity and that's why I think
11 communication is very, very important. Mr. Siegler
12 said before that Doctor Katz always says he can't
13 have enough communication and I think that's
14 really true because you might remember although
15 I'm a lot older than you in the mid 2000's when
16 the Berger commission came about which was a
17 commission that was set up by the state and it was
18 set up because in health policy circles it had
19 been for years said there are way too many
20 hospitals in New York State and there are way too
21 many in New York City and they need to… they're
22 inefficient and they need to either close or
23 downsize or merge and they came up with a list but
24 when… then the public heard about the list they
25 said well what do you mean there are too many

hospitals, we don't… we don't understand that, we don't know what that means, we don't know what, you know a hospital being too big means, we don't know what it means it has become inefficient and so I do think it's incumbent on all of us to have these conversations like we're having today to help people understand and, and when I said in the testimony that no amount of sophisticated analytical tools can substitute for having those community conversation so the people can understand what the plan is, where care is going to be provided not just after the transition or the transformation but during that transformational period as well and I do think… you know some of… some of this is tough because even at the end of that period if somethings different and there's been a change that's often hard for people to accept and I think we will always see situations where people would have preferred what used to be than to what is now but I do think we are undergoing as I mentioned before some real revolutionary changes and we have to figure out how to manage them best and communicate the best that we possibly can.

2 CHAIRPERSON RIVERA: So, I wanted to talk
3 about maybe one specific example you could give
4 of, of a hospital that has gone through a
5 consolidation and how that impacted the adjacent
6 community surrounding it and what that process was
7 like but if you… if you can't think of an example
8 I will give you an example. One of them that's…
9 it… right now and I mentioned in my testimony two
10 hospitals, one was Saint Vincent's which to me
11 and, and again I, I was around during the mid-
12 2000's by the way, Saint Vincent's was kind of
13 like it, it closed overnight compared to Mount
14 Sinai Beth Israel which is taking a little bit
15 longer to close and I, I wanted to… you mentioned,
16 you know get… being engaged with the community and
17 communicating but I think that that piece is
18 what's mission with so many of these hospitals and
19 so we hear that they're eliminating 200 beds here
20 and that they're closing a facility and it's going
21 from 800 beds, oh no 800 beds is… we don't really
22 have all those beds filled we only have 400 beds
23 now we're down to 300 beds, you know some people
24 feel like that's a self-fulfilling prophecy like
25 you're going to continue to cut the beds to meet

the needs of the transformation that you envision as an organization not necessarily led by the community. So, can you give me an example of maybe a hospital that went through a process that you feel was truly community led and were the public hearings engaging, did you… did you have good ideas that came from the advocates of things that you considered or you changed throughout the process because sometimes people feel like even when you come and you present to the community board and you have a slide show and you have a handout of the slide show that's all it is, it's a slide show with a Q and A and then you walk out the door and nothing else happens. So, we're, we're trying to hear from you that not all hospitals create their plan in, in the way that they want and are just looking for a rubber stamp, that you truly want to hear from the advocates and the people who are living through this every single day.

DAVID RICH: Well I think, and you know I'm, I'm not nearly as close to these individual examples as obviously our member hospitals are

2 because it's… they're the ones living through
3 them. I mean I do think… [cross-talk]
4 CHAIRPERSON RIVERA: And I wish… [cross-
5 talk]
6 DAVID RICH: …that… [cross-talk]
7 CHAIRPERSON RIVERA: …I wish they were
8 here today, I don't… I don't see them.
9 DAVID RICH: Yeah, well I think, you know
10 one of the… one of the issues I think for them is…
11 you know I think… I think it, it varies a lot and
12 I think… you know I don't believe that any one of
13 them would say that just coming to a community
14 board and doing one Q and A and one slide show
15 should be sufficient and you know they need to be
16 and I think they strive to be and if they're not I
17 think they know that maybe improvements can be
18 made to be dealing with the community in a way
19 that these conversations are ongoing and that
20 they're not just with particular people who sort
21 of you know always show up to a meeting but with
22 the different community groups that they're… that
23 access the hospital and work with the hospital. I
24 do think that… you know the other… the other point
25 to be made is that they don't get to just do these

2 plans on their own, you know the state government
3 has a huge role to play, I do hear you when you
4 say it’s not that easy to figure out like when
5 PHHPC is having hearings or when they’re… you know
6 how they’re exactly meeting and making their
7 decisions but you know that’s a process that, you
8 know potentially could be improved over time but I
9 think that as we’ve seen in the past they actually
10 will disapprove plans if they think that they are
11 not actually being… serving the community and that
12 they think there will be a demotion of services…
13 CHAIRPERSON RIVERA: Do you have an
14 example of one… a, a plan that was disapproved?
15 DAVID RICH: Yes. So, you might recall a
16 number of… this, this was probably the most
17 publicly obvious one that I can remember with Long
18 Island College Hospital back in the day. They had
19 asked to… because they had… they were bleeding
20 money, they had asked to actually discontinue
21 maternity services because they had a huge medical
22 malpractice bill that they were not going to be
23 able to continue to pay if they continued
24 maternity care, there was a big outcry not just
25 from the community, it’s not only the community

2 that has an outcry often, it was, you know
3 physicians providing those services at that
4 hospital, certainly work… the workforce and so the
5 state said no you can't do that. Now in that
6 unfortunate situation I think that decision
7 contributed to the decline of the hospital, as we
8 know that hospital doesn't exist anymore. So,
9 that's one example. Now I think what we've seen in
10 that situation as well as in Saint Vincent's, in
11 Westchester Square and a number of other places
12 around the city where there was a full-service
13 hospital before what the state has tried to do is
14 make sure that there are health care services that
15 remain there. There are places in the city where
16 hospitals close prior to… the ones I just
17 mentioned where there was not a plan to have any
18 services provided there afterwards and they are
19 unfortunately often as you can imagine a lot of
20 times when a hospital closes it's in one of the
21 most underserved areas of the city and there was
22 not a plan to make sure that there was even still
23 a free standing emergency room the way there is at
24 Saint Vincent's or the way that there is at
25 Westchester Square or the way that there is at the

2 former Long Island College Hospital site. So, I
3 think that's the kind of thing that we're seeing
4 more of now is trying to make sure that there are
5 still services there, it's not going to be all of
6 the services necessarily and that will also cause
7 some community concern but I think now we're in,
8 in a situation where we're having a lot more
9 planning going on than we've seen in the past.
10 CHAIRPERSON RIVERA: Well you know a lot
11 of the people that are here I've, I've worked with
12 around this issue and it… you know I, I… Lych
13 [sp?] was an interesting example to bring up, it's
14 not even there anymore but I, I want to just
15 stress that you… I, I hope that you'll stay for
16 the remainder of, of the hearing because not only
17 have they been patient but there are many people
18 here that have a lot to contribute about some of
19 your comments and how the whole certificate of
20 need process goes about in terms of truly engaging
21 the community so I guess, you know I, I, I thank
22 you for your testimony in case… do you have any
23 questions? And again I really do hope that you
24 stay to hear from some of the advocates here
25 because we have… we are really trying to work to,

2 to provide quality services and you know we're
3 really, really anxious about the future of health
4 care facilities and we understand that maybe you
5 don't need 800 beds on every corner but the way
6 that some of these hospitals are closing and this
7 land is being disposed of for, you know amenities
8 and, and benefits that are not for the public it
9 is really disturbing. So, I hope that we will stay
10 in touch in terms of some of the work that the
11 hospitals are doing, it, it, it disappoints me
12 that there aren't any voluntary hospitals here
13 unless I'm missing them that can speak to some of
14 the processes that they're going through
15 specifically the, the Mount Sinai Health System
16 and thank, thank you, I… thank you for your
17 testimony and for answering all of my questions.
18 DAVID RICH: Sure.
19 CHAIRPERSON RIVERA: And with that I'm
20 going to call up a panel; it's going to be Lois
21 Uttley, Judy, Judy Wessler, Arthur Schwartz.
22 [off mic dialogue]
23 CHAIRPERSON RIVERA: And again, I want to
24 thank you all for waiting. I, I, I was hoping that
25 you would have the patience to listen to the

testimony and I do value your input on anything that was mentioned during the previous panels. So, I guess… [cross-talk]

LOIS UTTLEY: I'm Lois Uttley, yes. Judy asked if she could go first, she has to leave and…

CHAIRPERSON RIVERA: Oh, yeah, you can go first. Is, is five minutes okay if I put the clock on? Okay, well Judy, you know we'll… if I wink you have a…

JUDY WESSLER: Thank you, thank you. Okay, I, I just… I wasn't going to testify but just hearing… how's that? I don't have written prepared testimony, I just jotted down some notes and, and I say… I mean there, there are examples of alleged movements from hospital to ambulatory care and I say alleged advisedly both for example Mount Sinai Beth Israel and NYU as well, let's not forget their encroachment as well or setting some of these clinics or offices in… around the community and saying that that's what they're doing to adjust for the fact that they're removing other services or closing beds. For the most part they are considered private doctor's offices and not necessarily part of the hospital and therefore

2 not required to take Medicaid and certainly not
3 take care of the uninsured and that has a
4 tremendous impact in terms of access within the
5 community. The… NYU just opened an Essex Crossing
6 in your… a little bit down from your catchment
7 area and is supposedly not taking Medicaid. Mount
8 Sinai Beth Israel on the west side for example,
9 there are a lot of what we call dual eligible
10 patients they have Medicare and Medicaid and
11 people are being told that they can use the
12 service but they will not take Medicaid so that
13 the person who is low income would have to pay
14 the, the… you know co-payment which of course they
15 can't do so it's limiting access to care while
16 claiming to be expanding care in the community
17 which I think is a very serious problem and
18 probably is happening in other places, those
19 happen to be the ones that I know about and that's
20 very serious. There are places like Mount Sinai
21 has set up a wonderful joint program a Denver
22 facility for, for asthma and treatment and, and
23 they don't Medicaid and when I asked about it I
24 was told that well the Medicaid patients can go to
25 the clinic even though again they are, you know

2 like three blocks away. The same is true for… I
3 had an experience at the NYU infusion center, I'm
4 a Gouverneur patient and I was refereed there
5 Gouverneur to Bellevue to NYU, I was very nervous
6 about going there because I don't love them, so I
7 brought a friend who happens to be an African
8 American woman nurse and she was the only person
9 of color in the whole facility. Again, you know
10 there… the, the… I want to say racism but, you
11 know it, it really is racism and, and a lot of
12 other things that we could call it so that's a
13 serious problem. In terms of DSRIP, you may know I
14 am a… the Assembly Representative on the State
15 Legislative of… I... it's called the PAYOP, I
16 always forget what it stands for but there was
17 absolutely no intention of contracting with
18 community based organizations and moving services
19 out, that was something that was pushed and forced
20 and is a little bit happening but certainly is not
21 happening the way that it should be happening and
22 so again, you know even though there are these
23 potential mechanisms to, to, to change what
24 happens and maybe move towards equity if it does
25 happen a little bit it's only because of the huge

2 fight and not because it's something that's… the,
3 the institutions are really interested in doing.
4 There was an ambulatory care committee of the
5 PAYOP and I don't even know what happened to it,
6 it sort of disappeared because, you know they
7 really weren't coming out with a plan and
8 demanding from the, the PPS's which was the
9 preferred provider systems which are primarily
10 hospitals. You'll give me a little more time,
11 right… that… primarily hospitals were not really
12 responding with ambulatory care plans even though
13 again when you transform a system that's part of
14 what the transformation should look like and just
15 to, to tie a little bit together, money makes a
16 difference and right now we have the issue of
17 charity care. The… and there is a work group that
18 was set up by the state to see about moving some
19 of the money around in charity care and that would
20 help to pay for uninsured care. I did a, a spread
21 sheet that shows that the… there are essential
22 safety net hospitals that are not getting much
23 money from these charity care pools but are
24 providing way more of the care for the uninsured
25 as well as for Medicaid patients. This is an issue

2 that's quite ripe right now and this work group is
3 supposed to come up with a proposal in December
4 and I wanted to say this here because we could
5 certainly use the support of the City Council and
6 I'd be happy to share the information that we've
7 developed in terms of seeing that that money
8 should go where it should be going for paying for
9 care rather than ten million dollars or four
10 million dollar salaries for executives which is
11 some of what's happening now and some of the
12 hospitals like NYU because they bought a hospital
13 in Brooklyn will be getting 51 million dollars and
14 you know it's just out of this pool so there's,
15 there's some really outrageous disparities and
16 they need some attention and that could hopefully
17 if the money was going where it should go could
18 influence where services would go, could go and
19 who could get care. So, I ask for that help.
20 CHAIRPERSON RIVERA: You have my undying
21 support you know that.
22 JUDY WESSLER: Thank you.
23 CHAIRPERSON RIVERA: Thank you.
24 LOIS UTTLEY: I'm Lois Uttley, Director
25 of Women's Health for Community Catalyst and the

2 Founder of the Merger Watch Project. Earlier this
3 year we published a report with the supports from
4 the New York State Health Foundation called
5 Empowering New York Consumers in an era of
6 hospital consolidation and I see that its
7 referenced in your briefing papers so I won't
8 repeat a lot of what you've already including in
9 your briefing paper but the main conclusion of the
10 report is that at a time when all this
11 transformation is happening in our health system,
12 hospitals closing and downsizing and merging and
13 care moving from inpatient to outpatient,
14 consumers feel bewildered by what's happening,
15 they don't understand it, they, they're not well
16 informed and nobody's consulting them about how
17 this transformation could be done in a way that
18 would be understandable, would address their needs
19 like for transportation, for… help for people to
20 navigate the new system. We basically concluded
21 that consumers and our representatives such as you
22 city council members often have little or no say
23 in the state oversight of this ongoing
24 transformation. So, I want to focus a little bit
25 on what we had to say about certificate,

2 certificate of need system. We concluded that the
3 CON system is not sufficiently transparent,
4 consumer friendly or responsive to local concerns.
5 So, for example it does not currently require
6 advanced notice to affected consumers and their
7 local officials when a hospital is going to close
8 or downsize, it's amazing. The state Public Health
9 Law only requires a public hearing 30 days after
10 the hospital closes, what good is that? We need to
11 have public hearings ahead of time. Health systems
12 that are taking over local hospitals are not
13 required to spell out their long-range plans for
14 their facilities, which could include down the
15 road downsizing or closure as we saw has happened
16 with Mount Sinai Beth Israel. There are no
17 consumer health advocacy groups currently
18 represented on that state CON review board, the
19 public health and health planning council. By law
20 there's supposed to be at least one consumer
21 representative and there is none. By law there's
22 supposed to be at least four representatives of
23 hospitals, nursing homes and other health care
24 providers and currently there are eight, so we
25 have twice as many industry representatives on the

2 council as is the minimum and we have no consumer
3 representatives. It would be really beneficial to
4 have representation on that PHHPC from consumer
5 health advocates particularly those who are
6 familiar with the needs of vulnerable populations
7 that we're concerned with here. Furthermore,
8 there's no formal process for this PHHPC in the
9 DOH to obtain and consider comments from local
10 officials such as members of the New York City
11 Council or the City Health Department about
12 proposed consolidation or transformation of health
13 providers. In the law there's supposed to be
14 getting recommendations from local health systems
15 agencies but I'm sure you're aware that HSAs were
16 defunded, and we have only one left in the state
17 out in Rochester, there is none in the New York
18 City area. So, at the PHHPC meetings when they're
19 reviewing recommendations from the, the DOH staff
20 about a particular transaction whether it's a
21 merger or an acquisition, downsizing there's a
22 line in the summary that says HSA recommendation
23 because they're supposed to be getting one and it
24 always says except in the case of those from the
25 Rochester area, NA, not available or not

2 applicable. That is not the way decision making
3 should be made, no consumers at the table, no
4 input from local officials like you. So, what
5 could you do about this? First of all, tell state
6 officials, the legislature and the governor to
7 ensure that health consumers and local officials
8 will be affected by hospital closures or
9 elimination of key services like maternity are not
10 notified and engaged. We recommend a requirement
11 for 90 days advanced notice when a hospital is
12 going to close or downsize. We think that
13 hospitals should be provided… required to provide
14 a proposed closure plan and take comments on that
15 plan at a public hearing in the affected community
16 at least 60 days in advance of the closing and not
17 during the daytime by the way, at night or on the
18 weekend when consumers who work can actually get
19 to it. We think there should be greater
20 transparency, consumer engagement and
21 accountability when health systems take over
22 community hospitals. We want a requirement that
23 health systems have to project out into the future
24 what they're likely to do where the community
25 hospitals are taking over so that we're not

2 surprised three years down the road by a plan to
3 close the maternity unit or close cardiac surgery.
4 We need to have appointment of more consumer
5 representatives to the PHHPC, we would love for
6 you to join some other public officials I'm aware
7 of who will be asking for this very shortly and in
8 general we think the CON process needs to be
9 reformed. It was created for a different era when
10 hospitals were expanding and the purpose of it was
11 to make sure we didn't get too many hospitals and
12 duplicative services, it's not suitable for the
13 current era of consolidation. I would note that
14 that CON chart that's in your briefing paper and
15 also in the testimony from Greater New York does
16 not make clear the fact that some of the CON
17 applications do not go through that process that's
18 delineated there. Those that are limited review,
19 administrator review, or notice are never coming
20 to the PHHPC and getting discussion in a public
21 meeting. We need to take a, a close look at that
22 as well. Thank you for the opportunity to testify,
23 I really have appreciated listening to your
24 questioning of the hospitals system officials and
25 I commend your work.

2 CHAIRPERSON RIVERA: Thank you.
3 ARTHUR SCHWARTZ: Am I on? Good afternoon
4 and it's, it's… I'm very excited to appear in
5 front of you Council Member this afternoon, this
6 is my first experience with you in this chamber.
7 I, I want to address the issue of disappearance of
8 hospital options and the process that people have
9 been talking about and to some extent I like to
10 tell stories so I'm going to tell some stories. I
11 lived for 24 years on West 11th Street, I could
12 walk to Saint Vincent's Hospital, it was three
13 blocks away. I went there in 2006 with symptoms of
14 a heart attack and had stints added to my heart. I
15 walked over there with… when my three-year-old had
16 appendicitis, I went there with my wife who was in
17 labor with our second child. I went there with my
18 80-year-old mother who was suffering from
19 diverticulitis, we were able to get to the
20 hospital immediately. Then Saint Vincent's
21 disappeared. One of the… one of the relevant
22 points I read about which was after, there were
23 studies that were done after the hospital closed
24 which showed that the residents of NYCHA's Fulton
25 Houses and Chelsea Elliot used Saint Vincent's,

2 most of the people that lived there used Saint
3 Vincent’s as their primary care facility as did
4 many low income people from Chinatown. But the ER
5 was also full of many people who needed admission
6 to the hospital. After Saint Vincent’s closed the
7 closest hospital was Beth, Beth Israel. Years
8 later a standalone emergency room was established
9 across the street from the site of the old Saint
10 Vincent’s hospital, but it has no beds or no
11 ability to do any sort of emergency surgery. On
12 the morning of the January 31st, last year, I woke
13 up knowing I was having a heart attack, my wife
14 drove me a block to the standalone ER which took
15 an EKG and said you’re going to Beth Israel
16 Hospital. I was horrified, I was horrified because
17 I had heard that Beth Israel was closing, I said
18 why there, they said well if you don’t go there
19 you’ll have to go to Lenox Hill on 69th Street. So,
20 luckily it was a Saturday and ten minutes later I
21 was at Beth Israel Hospital and luckily my problem
22 was dealt with, with three more stints in their
23 still open CAT Lab but I lay… learn, learned later
24 in the day that the heart surgery unit had been
25 closed the week before and if I had needed open

2 heart surgery I would have been shipped up to
3 Mount Sinai Hospital on 100th Street. When the
4 nurses at the hospital heard that I was the
5 community's district leader and that I had been…
6 come involved in efforts to keep Beth Israel
7 opened they chewed my ear off for two days about
8 how horrible the closure of the hospital was and
9 how needed it was for the impacted community. So,
10 as, as, as you know I undertook a campaign to
11 fight Beth Israel Hospital's closing. My research
12 found two things, first that the CON process which
13 is already deficient as Lois just discussed had
14 been short circuited. To avoid any public process
15 at all the hospital segmented its applications,
16 they broke each item down as to what… in… that
17 they were doing, and they said in their
18 applications that the cost of their action was 500
19 dollars. For example, the maternity unit closed, I
20 got the financials, they made 15 million dollars a
21 year from the maternity unit but on the CON
22 application they said there was a cost of 500
23 dollars, that allowed the process to go along
24 without any public notice other than on their
25 website, without any public hearings, without

2 public hearings in front of various Department of
3 Health bodies and the Department of Health went
4 along with this. The secret process which I think
5 is also applicable because of its impact on the
6 affected communities had also been ignored and
7 also perhaps in part because the hospital didn’t
8 think it applied and, and also because the
9 Department of Health allowed the process to go
10 forward in segmented way. The secret process would
11 have required a fully transparent public study of
12 the impacts full of numbers, discussions of
13 alternatives and public hearings in the community.
14 So, as you know last November I sued, Beth Israel
15 Hospital has not filed any new CONs since
16 November, I’m not going to take credit for it, but
17 they haven’t. Quietly… I kept quite about the
18 lawsuit while we navigated various motions to
19 dismiss I sued the, the Department of Health and
20 Beth Israel Hospital but last week Judge Hagler,
21 Judge Shlomo Hagler said he denied their motion to
22 dismiss and said that we could move forward. At
23 that hearing after the Judge said that they said
24 but Judge we’re going to substitute a 200 bed
25 hospital at the corner of 2nd Avenue and 14th

2 Street, the Judge said well they have 300 beds
3 filled now isn’t that enough and I said that’s the
4 first I think anyone has ever heard of this 200
5 bed hospital, no public process, no announcement,
6 no discussions even with your office which I know
7 has engaged them a great deal. My point, while we
8 continue to litigate this issue in court. I agree
9 that the use of the emergency room for primary
10 care is not a smart thing but it must be addressed
11 in a way that doesn’t penalize people who don’t
12 know that, that the matter that they’re going to
13 the emergency room for is not of a life
14 threatening nature that requires potential
15 admission, that is a very, very complicated
16 decision for people to make. The hospitals that
17 are closing their ERs and closing and
18 consolidation are making that decision for people
19 and telling them to go to clinics which will then
20 send them to hospitals if they’re… if their
21 problem requires hospitalization. The
22 disappearance of hospitals and the acute care
23 which admittedly, admittedly is more expensive and
24 less profitable is I believe becoming a crisis in
25 our borough and in every other borough in the

city. The current practice… the current practice of moving forward as you just said without fully transparent studies based on transparent data about current and… current usage and the impact of hospital elimination or partial elimination and without meaningful community input is wrong, it's dead wrong and probably has resulted in deaths. We cannot have people dying because a hospital… because hospitals are expensive, because hospitals need additional financing, we cannot have people forsaking procedures because the health system is concerned about the cost of a test or procedure. Thank you for your hearing.

CHAIRPERSON RIVERA: I have a, a… Lois you mentioned PHHPC and the lack of the, the seat that's been vacant for quite some time… [cross-talk]

LOIS UTTLEY: Yeah… [cross-talk]

CHAIRPERSON RIVERA: …and so I think everyone on the panel… and I want to thank you for all of your work Arthur, I know you've been working on this for a long time and thank you for sharing your personal story and Lois you mentioned the, the vacant seat and I absolutely agree that

2 the certificate of need process is incredibly
3 problematic and not truly inclusive of community
4 and public engagement and so I'm happy to work on
5 legislation in terms of a resolution that we could
6 send up to Albany and, and have them hopefully
7 pass it with a, a new body that we'll, we'll see
8 in January… [cross-talk]
9 LOIS UTTLEY: Great…
10 CHAIRPERSON RIVERA: Do you feel like if
11 we… if we fill that seat with someone who truly
12 understands what the consumer is going through and
13 who has patient care and advocacy as their
14 priority that filling that seat with someone could
15 truly make a change in terms of, of, of PHHPC and
16 their powers? So, the powers that they have and
17 how they exercise them, is it… is it really being…
18 is the community really being hurt by not having
19 this, this consumer advocate?
20 LOIS UTTLEY: Well the problem is there's
21 no consumer voice at the table at all now, that's
22 not to say that there aren't some very smart
23 people on that council and people who do
24 understand the needs of vulnerable populations,
25 there are but there's nobody who really can speak

2 up for consumers. There actually are two vacant
3 seats on the council right now and I don't see why
4 there can't be two consumer representatives
5 appointed since there are twice as many health
6 provider representatives as is suggested in the
7 law. What, what consumer representatives could do
8 is ask the right questions during those PHHPC
9 hearings. All too often the staff gives a summary
10 of what the applicant has submitted and there's a
11 few questions but not much and they have a very
12 packed agenda and they sort of rush through it and
13 there's no opportunity for people from the public
14 to testify either except at the committee meetings
15 and again those are very packed and I, I went to
16 every single one all of last year and I think I
17 might have been the only consumer who actually
18 testified about a hospital merger, consolidation
19 or downsizing. It's just not open and transparent
20 so I think at least getting one or more consumer
21 representatives on the PHHPC would be a good
22 start, but we also will need to probably help that
23 person because the volume of material that the
24 PHHPC members are asked to review on very short
25 notice is overwhelming, even some of the PHHPC

2 members complain about it. It’s often a thousand
3 pages of documents one week before the advance of
4 the meeting so only those council members who come
5 from big health systems and have assistants who
6 can read all this stuff for them and tell them
7 what it means can actually get through it and
8 understand it. We’ll need some help for those
9 consumer representatives.
10 CHAIRPERSON RIVERA: And I want to just
11 ask the, the, the both of you if you… I am very
12 much willing to lobby the Governor’s office to put
13 someone in those seats that we know… not… keeps
14 the consumer first and foremost in mind and who’s
15 willing to do the work, it’s a lot of work and…
16 [cross-talk]
17 LOIS UTTLEY: Yeah… [cross-talk]
18 CHAIRPERSON RIVERA: …and you’re both…
19 you have incredible resumes and reputations so if
20 you do have recommendations including yourselves
21 if you are up to it I would really love to submit
22 those names and try to lobby Albany to make sure
23 that we are putting the people that we need on
24 PHHPC.
25

2 LOIS UTTLEY: Thank you, several of us
3 did actually apply last year and never heard
4 anything back.
5 CHAIRPERSON RIVERA: Okay… [cross-talk]
6 LOIS UTTLEY: So, we, we appreciate your
7 help.
8 CHAIRPERSON RIVERA: Thank you.
9 ARTHUR SCHWARTZ: Thank you.
10 CHAIRPERSON RIVERA: Thank you so much.
11 And the next panel is going to be Heidi Siegfried,
12 Mark Hannay and Katelyn Hosey and please correct
13 me if I mispronounced your name. This will be the
14 last panel unless there's any other members of the
15 public that wish to testify, please fill out a
16 form if not this will be the last panel and I want
17 to thank the three of you for your unbelievable
18 patience today. Thank you so much.
19 [off mic dialogue]
20 KATELYN HOSEY: Sure, so I'm Katelyn
21 Hosey from Live On New York. Thank you for having
22 us here today. I just want to start with a little
23 background on Live On New York, so we are
24 membership-based organizations, we have about 100
25 community-based organizations that are our members

2 that operate senior centers, home delivered meals,
3 case management agencies, affordable senior
4 housing, etcetera. We also administer citywide
5 outreach program that helps older adults enroll in
6 SCRIE, Medicaid and other benefits so through our
7 work we really strive to make New York a better
8 place to age and I just wanted to come and give a
9 different perspective on today's hearing and I can
10 tell that it's one that's really valuable to the
11 people in the room and happy to have further
12 conversations with you all. So, one of the things
13 that we know in our work is that older, older
14 adults are the foundation of New York and help
15 build strong resilient communities. Centrally to
16 these communities are these older adults who give
17 back through caregiving for grandchildren and are
18 key sources of information in communication with
19 their family networks. With this in mind when
20 looking at the health care system in New York it's
21 important to ensure that one's view of health care
22 takes into account the full landscape of services
23 that an individual might seek in order to fulfill
24 their care needs and many of that will be for our
25 members senior centers, home delivered meals,

2 whatever that may be, trusted sources of
3 information in order to alleviate their concerns
4 about their health and to have a positive impact
5 on their overall health. So, I wanted to really
6 jump in to three specific examples of how our
7 community-based service network has impacts on
8 health. The first one that I'll get into is a
9 housing with services model that's actually…
10 recently had a study, our member Selfhelp
11 Community Services. They did a study of their
12 housing program that has a service coordinator in
13 the program to help with information and referral
14 and light services within the building and they
15 had a study of those individuals in that housing
16 as compared to individuals in the surrounding zip
17 codes and they were able to find a 68 percent
18 lower odds of hospitalization and for those that
19 are… were hospitalized an estimated 4,000 dollar
20 savings per person per hospitalization so just
21 really tremendous impact on health care spending
22 and even 53 percent lower odds of visiting an, an
23 emergency room as opposed to a different level of
24 care. So, these are interventions that are
25 community based that are often out of the

2 landscape of our traditional dialect in health
3 care conversations but one that we want to make
4 sure starts to get heard. Additionally, one thing
5 that I wanted to bring up is the recent challenge
6 related to information dissemination. The State
7 Department of Health just announced the closure of
8 certain managed long care plans, MLTC. The state
9 will be sending letters to patients with
10 information's regarding choosing a new plan so
11 this is something that our network, the case
12 management network serves about 33,000 clients a
13 year, they're actively preparing for this,
14 learning information about which of their clients
15 might be receiving these notices just so that they
16 can help troubleshoot moving forward. So, that's
17 just an example of sort of the one-off type work
18 that a case manager might be expected to do in
19 helping their constituencies navigate the health
20 care network and its really a, a tremendous cost
21 savings and a value to the overall, overall health
22 care system. So, finally I just want to talk about
23 a sort of more specific issue within the
24 community-based services world per se. The
25 community service-based sector we need to begin to

2 elevate them as partners to the health care world
3 and a lot of that starts with data. It’s very
4 difficult for a lot of community based service
5 organizations to have data that is going to be
6 able to participate in these DSRIP programs and to
7 be able to be seen as a viable partner to the
8 health care institutions and that’s something that
9 we need to be able to empower community based
10 organizations, to have control of their data, to
11 have access to their data to be able to serve the
12 individuals coming through their senior center and
13 whatnot. So, it’s just something that we at Live
14 On New York we are willing to work with whether
15 it’s the Department for the Aging, the state
16 agencies involved, health care institutions to
17 make sure that these conversations continue to
18 progress to make sure the best outcomes for the
19 health care institutions as well as the
20 individuals on the ground in our case older New
21 Yorkers. So, I really thank you for the
22 opportunity to talk today and to just shed a
23 little bit of a different perspective on things.
24 HEIDI SIEGFRIED: Oh, perfect. Hi, I’m
25 Heidi Siegfried, I’m the Health Policy Director at

2 Center for Independence of the Disabled in New
3 York so I guess I'm, I'm a good one to follow
4 because I'm also going to speaking about a
5 particular population. We are across disability
6 organizations, so we serve people with all kinds
7 of disabilities, you know people usually think of
8 the little wheelchair symbol when they think of
9 disability, but we serve people with hearing
10 impairments, visual impairments in addition to
11 mobility impairments also people with cognitive
12 conditions, mental health conditions, you know all
13 kinds of disabilities. We also have… we're a
14 navigator for the New York State of Health
15 Marketplace and we also have a community health
16 advocates program that helps people with the
17 problems that they have after they've enrolled in,
18 in health coverage, not trying to make it work and
19 we also have… we're… we have the independent… well
20 I can, it serves people with a managed long term
21 care plans and dual eligible. So, the… most people
22 with disabilities in New York City that… there,
23 there… we're… they are more likely to have health
24 insurance coverage rather than being uninsured but
25 they're more likely also to be using public

2 insurance which would be Medicare and Medicaid
3 and, and you know the age… the American community
4 survey statistics come out every year and they
5 just came out like last month and the same… they,
6 they give you all the stuff about health coverage
7 there and it's, you know the same thing. They also
8 give prevalence so you can see with all the five
9 different kinds of disabilities what the
10 prevalence is in New York but anyway, so when you
11 have providers as been described by Judy that
12 discriminate against, against people with public
13 health coverage you… they are discriminating
14 against people with disabilities as well and so
15 they really… you know they really are another
16 factor in this whole… in addition to racism we
17 have discrimination against people with
18 disabilities. So, people with disabilities… you
19 know our statute, our civil rights statute is the
20 Americans with Disabilities Act and it's not about
21 equality it's about accommodation so when a person
22 with a disability is trying to get equal access to
23 care they… it's, it's an individualized
24 negotiation with their provider and depending on
25 what kind of disability they have it… you know

2 it’s not just about accessible, physical offices
3 and things but if you have a cognitive impairment
4 and you need extra help in filling out forms or if
5 you need help in, in getting dressed and undressed
6 it’s usually… a lot of times it’s, it… the idea is
7 that its going to take more time and you have to
8 basically train your provider how to provide care
9 to you and so when we see all these kinds of
10 disruptions and, and transformations in, in the
11 health care, in networks and people have to change
12 their providers it’s really… it’s really a big
13 deal because you’re going to have to train your
14 provider again, you know how to accommodate your
15 disability and so that’s, that’s one of the things
16 that we hear from, from our folks about when, when
17 hospitals close or providers get dropped from
18 networks or that kind of thing or… and in fact
19 with DSRIP as well and, and… the Gil Neck closure
20 is having a big impact also on people with
21 disabilities, I’m glad you brought that up because
22 they were… they were a plan that knew how to
23 provide care an adequate number of hours to people
24 that needed home care and as a result they went
25 bankrupt. Like Judy said it is… you know it is a

2 matter of money often and we are not putting
3 enough money into the system to, to help our, our
4 high needs… our high needs patients. Since I have
5 a little bit more time I'll just mention about
6 DSRIP and CBOs. We are obviously a CBO, we
7 obviously provide, you know real value added to,
8 to the… to these PPSs, we don't just help people
9 with health care problems we also help people get
10 their food stamps, housing assistance, all kinds
11 of assistance like that but you know nobody was
12 interested in contracting with us to, to, to help
13 provide these valuated services and of course a
14 person with a disability who comes to us they walk
15 in the door and we're going to serve them so, you
16 know they get away with getting our services with
17 us scrambling constantly to, to find funding. So,
18 that's, that's just… that's just my comment on, on
19 what… as a CBO, we've experienced with DSRIP.
20 MARK HANNAY: Good afternoon, I'm Mark
21 Hannay, I'm Director of Metro New York Health Care
22 for All, we're a citywide coalition of community
23 groups and labor unions that work… do health care
24 advocacy work together. I'm also sort of wearing
25 my own hat as an individual patient, I'm a

2 constituent of yours and I've been a patient Beth
3 Israel Medical Center a few years ago. I also in
4 the early 1990's used the dental clinic at
5 Gouverneur Hospital and most recently I was a
6 patient for scheduled surgery at NYU Medical
7 Center, so I've sort of run the gambit of… up 1st
8 Avenue there in the Lower East Side. So, my
9 testimony kind of reflects both my professional
10 experience as well as my personal experience. I
11 just kind of wanted to lay that out there and
12 although my own… in my own professional work I'm
13 primarily focused on issues of health insurance
14 coverage as opposed to delivery system issues. We
15 really look to our sister coalition, the
16 Commission on the Public's Health System for
17 leadership and guidance on that and support them
18 and work with them on that and I just wanted to
19 kind of call that out and make note of that. But I
20 guess what I've seen over the last decade or so as
21 hospitals have closed and merged and downsized a
22 few things kind of jump out at me that I thought I
23 would raise at today's hearing. And one is and
24 this has been mentioned by others at this hearing,
25 the real importance of community engagement and I…

2 and particularly from the get go, it's not just a
3 matter of coming in and saying hi, here's our
4 plan, what do you think of it but really… so, it
5 becomes a FATA comply but really engaging the
6 community in developing whatever plan is going to
7 happen from the start so that the community
8 understands itself as proactive partners in the
9 process versus finding themselves as reactive
10 adversaries. So, that's one point I wanted to
11 make. The second point in terms of services in the
12 community. As services move from an outpatient…
13 inpatient settings to outpatient settings and I
14 don't think anybody has a problem with that in
15 principle, we'd all rather be getting services at
16 home or in the community rather than a hospital if
17 we can avoid it but as Mr. Rich mentioned there
18 are circumstances where inpatient services are
19 required and so the hospitals certainly have a
20 role to play in our community but as those
21 services are moved into community based settings I
22 think the key is too that the community is often
23 concerned about is proximity so, that… okay, as,
24 as… can I still… in the case of Mount Sinai Beth
25 Israel for instance, if I need labor and delivery

2 services can I still do… and I live on the Lower
3 East Side can I still do that in relative
4 proximity to my home and my family and so forth or
5 must I go all the way up to 100th Street to deliver
6 a child and I think that's a key issue although
7 the system looks at it from an efficiency
8 standpoint that yes, it may make more sense from
9 their point of view to have you go up to 100th
10 Street to do the delivery. It's from the
11 communities and family and person's, patient's
12 point of view it's not desirable at all. And then
13 just lastly, I will just mention that I think we
14 as advocates and the community in general I think
15 its New York's tradition of nonprofit and public
16 health care needs to be protected and preserved
17 because it thinks the fundamentals of that drive
18 how patient care is delivered either in the
19 inpatient setting or the outpatient setting. Then
20 I have a few recommendations to offer that are a
21 little more detailed that sort of fall into three
22 buckets. One is around issues concerning
23 individual patients themselves. The second, the
24 community and sort of a third bucket is around
25 larger system issues so I'll just kind of run down

2 that quickly. I think it’s important from the
3 patient’s point of view that the full complement
4 of services be available in the community as they
5 are moved from outpatient settings, sort of a…
6 from inpatient to outpatient settings sort of the
7 concept of a hospital without walls that
8 everything is kind of still there. That support be
9 provided for family and informal care givers if
10 we’re moving things out of institutional settings.
11 I know in my own situations when I was discharged
12 a lot of it fell on me and close friends and
13 family and so forth and we weren’t always well
14 prepared for whatever we needed to do, and this
15 was mentioned earlier but to have smooth
16 transitions that aren’t particularly rushed. The
17 importance of having professional and
18 paraprofessional services available in the home
19 and community based setting, the use of community
20 health workers I think is something that is
21 important and the importance of community health
22 education programs out in the communities so that
23 members of the community can understand how to
24 take care of themselves, utilize the health care
25 system efficiently, keep themselves healthy and so

2 forth. As has been mentioned by others the
3 importance of engaging local non-profit community-
4 based organizations particularly in… as helping to
5 address the social and economic determinates of
6 health to keep people healthy. The importance of
7 evening and weekend hours for services I, I think
8 is something that is important. Sort of more
9 community things, I mentioned the engagement of
10 community-based organizations. I want to mention
11 one thing that I, I know exists in the public
12 system that I think is important but I'm not sure
13 to what extent at all it exists in the private or
14 voluntary system and that is that each facility
15 and its network has a community advisory board. I
16 think they have a really important role to play
17 that the board meets regularly and its consulted.
18 The importance of ongoing community engagement
19 with the community health needs assessments that
20 are required of facilities under the affordable
21 care act and the assessments that are done after
22 the fact of how many services were actually
23 delivered when all was sort of said and done to
24 the community and again involving the community
25 from the get-go in that… in a proactive manner.

2 And lastly, in terms of the community I think it's
3 important for health care systems to regularly
4 engage on an ongoing basis with the community
5 boards. At… each and every community board has
6 some sort of committee that deals with health and
7 human services and those facilities need to be
8 regularly engaged in that and to use those
9 community boards as… in lieu since we don't have
10 any health system agencies anymore, perhaps they
11 could become somewhat of a de facto health
12 planning entity in the community working with the
13 borough president, working with the council,
14 working with the mayoral administration so that
15 there is some proactive health planning that
16 happens across our city. And lastly, in terms of
17 the community concern, making sure that as
18 services are moved out into the community that
19 they're easily accessible by a means of public
20 transit, I, I, I think that's important. That the
21 services are nearby to traditionally underserved
22 and higher need communities, I'm thinking
23 particular… and populations naturally occurring
24 require… retirement communities, public housing
25 campuses, stuff like that that the services are,

2 are readily accessible to them. Lastly, just the
3 larger system is you, you touched on that with
4 your conversation with Lois Uttley about the
5 importance of oversight of hospital and health
6 systems, it's… the, the state has it's role,
7 perhaps there's a role that the, the city local
8 government could develop and play particularly
9 around issues of planning, implementation of those
10 plans, holding the elements of the system
11 accountable. And lastly, I just want to touch sort
12 of on the intersection of delivery system with
13 insurance coverage because I think one effects the
14 other. As services are moved out into the
15 community I think it's important that the new
16 entities that come forward are parts of health
17 care plans and that includes Medicaid plans, our
18 essential plan plans, the Medicare advantage plans
19 and the private qualified health plans that are
20 available on the New York City of Health
21 Marketplace. We need to make sure that provider
22 entities are contracting with all of those plans
23 so that… I have… whatever coverage I have is
24 meaningful for me to use and that those… [cross-
25 talk]

2 CHAIRPERSON RIVERA: If you… if, if I
3 could ask a, a question… [cross-talk]
4 MARK HANNAY: Uh-huh…
5 CHAIRPERSON RIVERA: And it's… and it's
6 also for the providers do you find that a lot of
7 the, the people that you serve or your members
8 when something like this happens, when a
9 transformation is underway in, in their community
10 are they looking for more community based
11 organizations to go to rather than the hospital,
12 do they come to you for these sorts of referrals
13 and references or are they more kind of in panic
14 mode because their local hospital is closing down?
15 I'm… I say that because the Gotham network we, we
16 want people to visit more community based… [cross-
17 talk]
18 MARK HANNAY: Uh-huh… [cross-talk]
19 CHAIRPERSON RIVERA: …clinics and clearly
20 that's in partnership with you all, you are the
21 frontline people that speak to just the everyday
22 New Yorker and so do you find that people come to
23 you for these references or referrals or that when
24 a hospital is closing it's more of a, a panic mode
25 because they just don't have the information?

2 HEIDI SIEGFRIED: Well we were… I… you
3 know I… we were a little bit involved with the
4 Saint Vincent's closing and we participated in
5 that study after the fact, I mean I think… I think
6 our community health advocates did get calls,
7 calls from people that were looking for how they
8 were going to continue to get their care, but I
9 mean I think a lot of times… I mean it really is…
10 I mean when, when Doctor Katz talks about the
11 patient relationship I really liked that because I
12 mean and especially for people with disabilities
13 that relationship is so key and so that's why, you
14 know they, they basically want to keep the
15 providers they have so when there's like changes
16 in health plans for example that… I mean you're
17 trying… and, and especially people who have
18 complex care and they have a whole bunch of
19 different providers it's really hard to be able to
20 continue, you know to see the providers that you
21 want for them all to be in the same plan and then
22 to have your formulary be on it so that's the kind
23 of work that we do. I put out a call about, about
24 the… about the Mount Sinai issue and I did get
25 some emails back from, from consumers that were

concerned about it and did come to the PHHPC meeting actually to… you know to testify, and they were… I mean they were concerned. I, I… like Mark was saying about this proximity issue, you know they were concerned about how they were going to get up to, you know Columbus Circle or 116th Street or whatever not just for… not… it wasn't an issue of just people that need care but also their family members who might want to visit them who might have a disability that have to use Access-A-Ride which is like hopeless and you know maybe the… they have to use public transportation that would be… it would be better if the thing was like in the… that, that… if their loved one was in a facility in, in the neighborhood so… I mean that's, that's the main things that I can think of that we heard from our consumers.

KATELYN HOSEY: I, I, I would echo a lot of that, I think… well I can't speak specifically to a, a recent proposed closure or one that has gone through, I think that senior center directors specifically often active hubs of information for everything going on in the community and as sort of an information source and I can actually… I

know that this isn't exactly the same but recently there were a lot of federal proposals related to SNAP and there was a lot of concern among the senior community about what was going to happen and if their food stamps were going to be at risk moving forward and even that… even though that was not going to be happening and there was a lot of steps in that process that still needed to happen there was a lot of information and explanation that needed to be happening from senior centers, directors, case managers, etcetera and I would imagine it's the same in regards to health care situations, the MLTC is a good example of that where they're certainly preparing to assist their clients with a transition.

CHAIRPERSON RIVERA: Well thank you, thank you. Did, did you want to… [cross-talk]

MARK HANNAY: I just had… [cross-talk]

CHAIRPERSON RIVERA: …add something…

MARK HANNAY: …one last point was related to this, I, I think one thing that's confusing for patients often times is they have an insured network but also then their provider network is sort of another network and they may or may not

overlap and that becomes really confusing so what I would like to urge both insurers and providers to do is to start to sync up your networks because it would make it a whole lot easier for you and for your patients so…

CHAIRPERSON RIVERA: And I, I agree and I think that one thing that H and H mentioned that they're working on is a more streamlined way to get people to see a primary care physician or a specialist and hopefully the right hand talks to the left hand because I know it can be incredibly intimidating even navigating my own health system so… [cross-talk]

MARK HANNAY: Right, right.

CHAIRPERSON RIVERA: Thank you all, thank you so much…

MARK HANNAY: You're welcome… [cross-talk]

CHAIRPERSON RIVERA: Thank you for your… [cross-talk]

MARK HANNAY: …thank you for holding… [cross-talk]

CHAIRPERSON RIVERA: …time… [cross-talk]

MARK HANNAY: …this hearing.

2 CHAIRPERSON RIVERA: Yeah, I, I just want
3 to say thank you to everyone who was here today.
4 Clearly, I think we all agree that it has to be a
5 holistic approach when we're talking about health
6 care and that discrimination really does exist
7 when it comes to policy around health care and
8 that, that lack of quite honestly social and
9 racial economic justice in terms of treating
10 health care as a fundamental human right. So, I
11 think community engagement is key right out the
12 gate and I hope that with some legislative changes
13 maybe to the certificate of need process or even
14 just getting adequate representation on something
15 is important on PHHPC, that I look forward to
16 working with all of you and of course to H and H
17 and the volunteer hospitals and, and that
18 protecting health care in a nonprofit and
19 community led way is, is so critical so I just
20 want to thank everyone and if there are no other
21 members of the public that wish to testify this
22 hearing is adjourned.
23 [gavel]
24
25

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 October 15, 2018