NYC HEALTH + HOSPITALS

New York City Council Hearing

Fiscal Year 2019 Preliminary Budget

Committee on Hospital Systems

Mitchell Katz, M.D.

NYC Health + Hospitals

President & Chief Executive Officer

March 15, 2018

Good afternoon Chairperson Rivera and members of the Committee on Hospital Systems. I am Mitch Katz, M.D., President and Chief Executive Officer of the NYC Health + Hospitals ("Health + Hospitals"). Thank you for the opportunity to review the Fiscal Year 2019 Preliminary Budget and some programmatic initiatives.

When I testified before the committee two weeks ago, I laid out my priorities for the system. To summarize, these are to invigorate and expand primary care, improve access to needed specialty care, and bring fiscal solvency to Health + Hospitals. I enjoyed our conversation two weeks ago and I am very grateful for your partnership to advance these shared priorities. Since we are here to talk about our budget, let me address fiscal issues first.

Over the past year, Health + Hospitals has worked to reduce costs by $387 million and increase revenue by $820 million in order to meet our $1.2 billion target. Due to the hard work of our staff, the delay in federal funding cuts and strong partnership with the city, I am able to report that we are on track to close the fiscal year with a projected balance of $250 million. We still must take action to address our core fiscal challenges and out-year risks.

Some of the initiatives to decrease costs this year include:

- Negotiating for lower prices on products and improving our supply chain operations to save $133 million;
- Refocusing our resources on doctors, nurses, pharmacists, and social workers through attrition and reductions in our managerial workforce - $250 million;
- Eliminating $16 million of consultant costs over the past three months; and
- Decreasing administrative staffing at central office by 35 positions for an annualized savings of $4.9 million.

On the revenue side of the equation, our work this year will result in:

- $110 million through improved billing and revenue cycle initiatives;
- Additional MetroPlus revenue of $84 million;
- Expanded value-based payments of $120 million;
- Increase in Delivery System Reform Incentive Program funds of $60 million;
- Care Restructuring Enhancement Pilot program funding of $125 million;
- Federally Qualified Health Center increase in rates of $25 million; and
- The 2-year delay in cuts to Disproportionate Share Hospital funding, which will yield over $600 million over two years.

These actions have enabled Health + Hospitals to meet our budget targets while making the organization more efficient and effective. But much more work can, and has to be done, to make Health + Hospitals a more resilient organization and lessen our future budget shortfalls. The out-year risks reinforce the need to take action now. It is worth repeating what I mentioned last month. My prescription for improvement includes:

1. **Reduce administrative expenses.** Attrition has been a successful tool for decreasing the headcount at Health + Hospitals without jeopardizing care. We have reduced head count by more than 4,900 positions since November 2015. I will continue to use attrition for non-clinical, non-grant funded positions, but having made a sizable reduction, we have likely obtained much of the benefit that can be achieved through this means. Where possible, I will look to reduce administrative expenses and shift staff into more strategically important functions so that limited resources can be directed toward patient care and the people that directly support it. Let me assure you that I have our patients'

interests at the forefront and will not take any actions to jeopardize quality or safety.

2. **Bill insurance for insured patients.** The majority of our patients are insured. We need to capitalize on this to recoup as much as we can from insurance companies which will help to cover the costs for uninsured patients. While Health + Hospitals has lagged behind on billing, a concerted effort on revenue cycle optimization is underway now and is already reaping over $100 million in benefits. It will take us two to three years to fully realize this previously lost revenue but I am certain that there is significant opportunity in this area.
3. **Code and document effectively so that we can receive the payment we deserve.** This goes hand in hand with billing. Proper coding and documentation for billing insurance companies must contain the information necessary to receive the full payment. Teaching people how to code records correctly can be the difference between fair payment from insurance companies and collecting tens of millions of dollars in underpayments.
4. **Stop sending away paying patients.** To stress what I said last month, I have learned that in many different parts of our system we discourage or even prohibit the care of insured people. There is a widespread urban myth at Health + Hospitals that insured patients should be referred out so that we can focus on care for the uninsured. This results in lost revenue and Health + Hospitals paying outside providers for the care of our own MetroPlus patients.
5. **Invest resources into hiring positions that are revenue generating.** As I reduce administrative costs, I need to look at the other side of the coin and hire revenue generating positions, including primary care doctors, nurse practitioners, pharmacists, and other specialized professionals. This has a twofold benefit of both increasing access to timely care and generating much needed new revenue from additional visits.

6. **Start providing those specialized services that are well reimbursed.** Health + Hospitals is the largest provider of behavioral health in New York City, and one of the largest providers in the country. These services are poorly reimbursed, but I am happy to do them because they fit our mission. What I do not agree with is the idea that we would not do services such as cardiac angioplasty that are well reimbursed. In the case of angioplasty, not only do we lose money when we need to send our patients elsewhere, but ambulances with patients with chest pain have to bypass our hospitals because we are not providing the right mix of services. This is going to change across the system, with Coney Island Hospital leading the way.
7. **Convert uninsured people who qualify for insurance to be insured**. New York City has had success in increasing insurance for those eligible. The Mayor announced last week that approximately 80,000 New Yorkers were enrolled in health insurance programs through the GetCoveredNYC campaign. This is great news and I want to build on this success and work to make it easier for patients to gain insurance. This helps them and helps us because insurance company payments will be much larger than the copays low income uninsured people can afford and patients will have real coverage.

I am confident that we can succeed in these efforts through hard work, determination, and partnership with this committee, City Hall, and all our wonderful staff. It will not be easy and it will not be quick but we must take steps now to ensure our long term financial health.

As I've mentioned, we cannot simply cut our way out of our financial challenges. We need to make investments that can generate revenue and improve patient care. One area where investment remains critical is in our patient care

infrastructure – if done responsibly, this can increase access and generate revenue from new patients. Health + Hospitals completed renovations at several sites over the past year to increase access to primary and specialty care. Through the Mayor's Caring Neighborhoods initiative, we are expanding in the Bronx, Brooklyn and Queens. Expanded services at these sites will now include comprehensive primary care and specialties based on community needs, which include behavioral health, cardiology, endocrinology, and after-hours urgent care. The seven sites will be able to serve 42,000 more patients than before the expansion.

In addition, we are looking to add staff and increase service offerings where they are needed at our existing sites throughout our system, as well as adding hours where it strategically makes sense. I would look to partner with the Council and others to increase awareness of the expanded services at these sites.

On Staten Island, we are in the final stages of opening a new $28 million community health center. We will offer pediatrics, women's health, behavioral health, asthma care, diabetes care, radiology, ophthalmology, podiatry and walk-in services. After we receive final approval from the New York State Department of Health, we expect to open this spring.

Our expansions have not been exclusively for outpatient care but also post-acute care services. Last month, we hosted a ribbon cutting ceremony to mark the opening of 60 new beds at NYC Health + Hospitals/Gouverneur. With the addition of these beds, we will now accommodate more clinically complex and short-term rehabilitation patients. The new space is designed to reflect a modern therapeutic environment that is more home-like than what you would normally think of for a skilled nursing facility. The rehabilitation area features state-of-the-art equipment to serve the needs of patients recovering from heart attacks, strokes, traumatic brain

injuries, and other debilitating conditions. My thanks to the Chair and Council Member Margaret Chin for joining us at the event.

We are also investing in improving the quality of care. For example, our work through OneCity Health, a subsidiary charged with changing the way health care is delivered and paid for through the State's Delivery System Reform Incentive Payment (DSRIP) program, we are helping to transition from volume-based payments to value-based reimbursement from the federal and state governments. OneCity Health and community partner organizations are striving to improve quality and outcomes through standardized care and a population health approach, increase primary care access, improve the patient experience and ensure financial sustainability through value-based contracting and community partnerships.

Some of the work that OneCity Health performed helped to guide recent efforts to implement a care management program. We recently announced a system-wide care management program designed to improve access to care and health outcomes for thousands of New Yorkers most at risk of frequent, preventable hospitalizations and emergency room visits. The model incorporated best practices from several programs and will target intensive navigational resources to patients with greatest need, regardless of insurance or immigration status. We will have dedicated care coordinators who will guide patients through the range of health care services, as well as work with community partners to address social determinants of health, like housing and access to healthy food. This program will expand to cover our system by the end of this year.

Investments in quality improvement activities are not just good for patients, they can be good for Health + Hospitals bottom line. For instance, we've increased the amount of value-based payments and quality bonuses we received by $120 million, increased Delivery System Reform Incentive Program funds by $60 million

and received Care Restructuring Enhancement Pilot program funding of $125 million. These new funding streams are made possible by smart investments in clinical services and improving quality.

There are several areas of investment that are central to our mission but do not have the same near-term benefit for our financial performance. As I've mentioned, we provide the majority of inpatient psychiatric treatment and behavioral health services in New York City. Many other providers have scaled back these services and as a result, mental health care in New York City is in need of expansion. Recognizing this shortfall, we've broadened access to behavioral health services and are continuing to integrate behavioral health and primary care to provide more comprehensive care to our patients.

Last year, universal depression screenings for adults in primary care practices across the City became common practice at Health + Hospitals. Similarly, we screen all pregnant women and new mothers for maternal depression and linked to care. On-site behavioral health services are provided by Health + Hospitals at each of the city's five Family Justice Centers, which provide a comprehensive range of services to survivors of domestic violence.

For those New Yorkers suffering from opioid addiction, we are screening patients for harmful substance use in our primary care clinics and providing team-based care. Our work over the past year has been to focus on addiction prevention, training physicians about pain management without prescription opioids and/or with less frequent prescription opioids. To prevent overdoses, we now have routine naloxone dispensing in clinical settings (Emergency Departments, Substance Use and Behavioral Health Clinics, Opioid Treatment Programs). Naloxone kits are now available to the community for free at NYC Health + Hospitals/Lincoln. This will

be expanded to all of our hospitals this year. Everyone who receives a kit will be trained on how to use it and you do not need a prescription to receive one.

One of the questions that came up at our last hearing was how many providers we have who can prescribe buprenorphine. By 2020, we will have increased the number of providers to 450 who are certified to prescribe buprenorphine. Through our efforts, the number of patients who received medication assisted treatment in our system will increase to 2,500 over the next three years. Additionally, we have addiction medicine consult teams at four of our facilities to care for our hospitalized patients with substance use disorders. Our goal is to ensure that 5,000 more New Yorkers gain access to medication-assisted treatment, buprenorphine and methadone, by 2021.

I will now turn to the Capital budget for a brief overview of some projects for which we have received Council funding.

- I want to thank Council Member Debi Rose for her generous contribution to our future community health center on Staten Island.
- I also want to thank Council Member Mathieu Eugene for his ongoing contributions to NYC Health + Hospitals/Kings County.
- We are renovating and expanding the adult emergency room at NYC Health + Hospitals/Elmhurst. We expect that it will be opened in phases given the complexity of constructing space in an active Emergency Department. We would like to thank the Queens Borough President and the Queens City Council delegation for their support.
- We are very close to completion of renovations to the Roberto Clemente clinic in Manhattan. This vital site provides behavioral health services to many residents on the Lower East Side. We would like to thank Chairperson Rivera,

former Council Member Rosie Mendez and the Manhattan Borough President for their support.

And a thank you to all the members who have supported new equipment purchases at our facilities. Your support enables Health + Hospitals to provide better care to our patients. Another important component of our capital program is the ongoing work to rectify the damage caused by Hurricane Sandy and to make our facilities more resilient to protect them from future storms. Projects to relocate and/or protect critical infrastructure equipment including electrical, mechanical, heating and ventilation units as well as projects to mitigate the effects of floods have been completed at the Bellevue, Coler, Coney Island and Metropolitan sites.

We will build a new hospital tower at NYC Health + Hospitals/Coney Island with an elevated emergency department and some of our inpatient services. Demolition is underway now on existing buildings to make way for the new tower which will take approximately four years to fully complete. While this work is underway, short term storm barriers have been put in place to protect the hospital in the event of a future storm.

As we upgrade our physical infrastructure we are also progressing through the upgrade of our new electronic infrastructure – Epic. This state-of-the-art electronic medical record system has been installed at three of our acute care hospitals now and will continue to rollout in stages with an expected completion date of 2020. Our new enterprise electronic medical record system will improve clinical care, as well as documentation to support our efforts to bill and code optimally, reduce claims denials, and accelerate receipt of reimbursement. Also, we are currently standardizing a new billing component that will integrate seamlessly and standardize revenue collection across our acute care, and long-term care facilities, as well as our ambulatory care sites.

Before I conclude, let me speak about our work in Correctional Health Services. With over 50,000 admissions per year and an average daily population of approximately 9,000 in twelve jails citywide, at the NYC Health + Hospitals division of Correctional Health Services, we operate one of the nation's largest correctional health care systems. We deliver health care to patients from pre-arraignment through discharge, providing medical and mental health care, substance use treatment, dental care, social work services, discharge planning and re-entry services 24-hours a day, 7-days a week.

Over the last two years, we have received funding to expand and improve services. For example, we:

- Operationalized the 24/7 enhanced pre-arraignment screening unit (EPASU) in the Manhattan Detention Center, which helps us to better identify and respond to acute medical and mental health issues before people enter DOC custody. The City funded in the FY19 Preliminary Budget an expansion of EPASU so CHS can replicate this model in the other borough courthouses.
- Nearly tripled the number of patients receiving Hepatitis C treatment, with 95 patients treated in the first half of FY18, compared to 34 in all of FY16.
- Opened seven satellite clinics to bring our services closer to patients.
- Opened two new specialized housing units for patients with serious mental illness, called Program for Accelerating Clinical Effectiveness (PACE). This brings us to a total of six PACE units in operation.
- Nearly tripled the number of daily patients on methadone maintenance and buprenorphine, and have distributed thousands naloxone kits to members of the public at the Rikers Island visit center. The FY19 preliminary budget

includes funding that will enable us to expand the naloxone distribution program citywide.

- Will conduct a Queen's pilot to streamline the conduct of court-ordered forensic psychiatric evaluations of fitness-to-stand-trial examinations.
- Will enhance mental health services for women in jail.

As you know, the age of criminal responsibility will raise to 18 this year. In New York City, both 16- and 17-year-old children in custody will be removed from Rikers no later than October 1, 2018. We are working closely with City agencies to ensure that health care is provided without disruption and in a manner that best supports the positive development of these adolescents.

As the City embarks on its ambitious plan to create a smaller, safer, and fairer correctional system over the next decade, we are a critical partner in planning the future system and how quality health care will be provided to a changing patient population.

We are thankful for the support that we have received to improve health care in the City's jails and better prepare our patients to leave jail and not return.

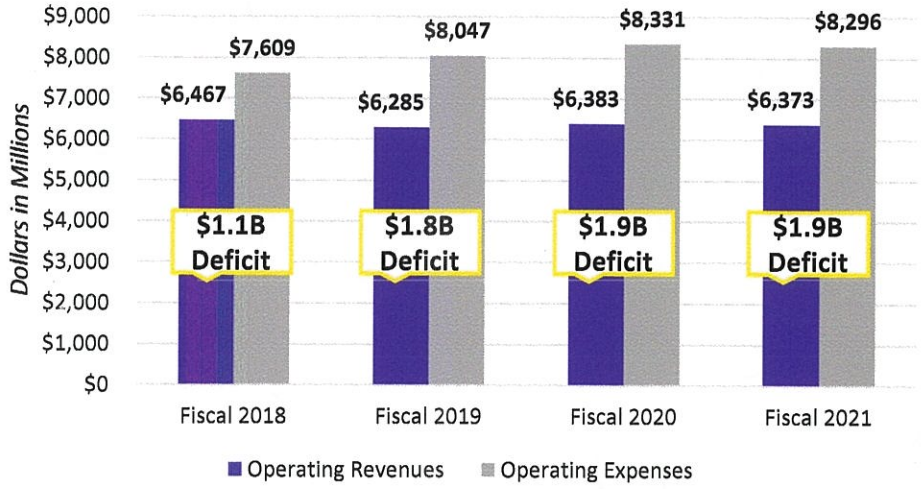
This concludes my testimony. I look forward to hearing your comments, answering your questions, and partnering with you to improve Health and Hospitals for all the people of New York.

NEW YORK CITY HEALTH + HOSPITALS – FISCAL 2019 PRELIMINARY BUDGET

Transformation Plan
Initiatives to Close the Gap

	Revenue-Generating	Expense-Reducing
FY18	$820M	$387M
FY19	$1.1B	$619M
FY20	$1.1B	$748M
FY21	$1.1B	$748M

Projected Operating Revenues & Expenses
Without Corrective Actions

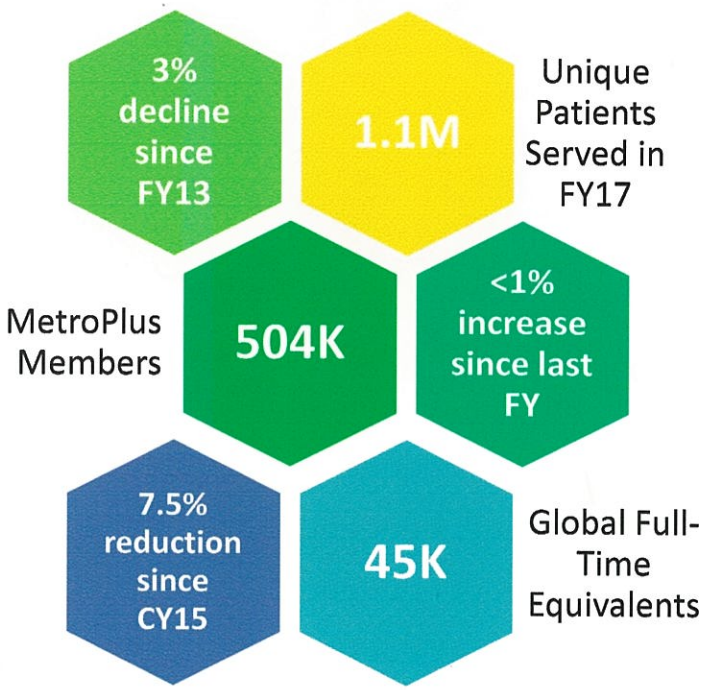


Fiscal 2019 New Needs

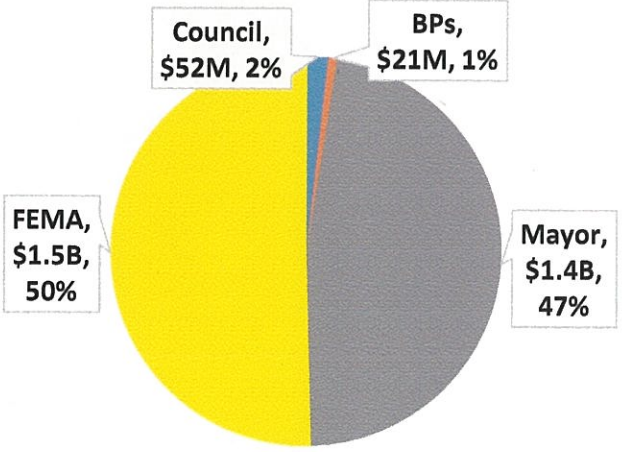
- **$79K** to enhance health services for LGBTQ youth through the NYC Unity Project
- **$954K** to hire five forensic examiners to reduce completion times for CPL 730 mental fitness exams

Correctional Health Services

- **$3.9M** to expand enhanced pre-arraignment screening units to the Bronx, Queens, and Brooklyn/Staten Island
- **$1.2M** to provide counseling and therapy through the Women in Rikers Initiative



H+H's FY18-11 $3.1B Capital Commitment Plan



Analysis based on H+H's most recent available plan, as of the Fiscal 2018 Executive Budget

Jeanette Merrill, Financial Analyst
NYC Council Finance Division

FOR THE RECORD

OFFICE OF THE BROOKLYN BOROUGH PRESIDENT

New York City Council
Committee on Hospitals
Testimony of Brooklyn Borough President Eric L. Adams
Thursday, March 15, 2018

Good afternoon Chair Rivera and members of the City Council Committee on Hospitals. My name is Eric L. Adams, Brooklyn borough president, and I represent the 2.6 million residents who call the borough home. As we are all aware NYC Health + Hospitals has been facing a financial crisis for years, while concurrently the health of the people they serve is in decline. Chronic diseases are at the highest levels in low-income communities and communities of color. As H+H continues to restructure, there is an opportunity to find funding streams for new initiatives and projects. I am pleased to testify on some of these important ideas.

For one, access to proper nutrition is a high-priority and personal initiative. After being diagnosed with Type 2 diabetes in 2016, I made a significant change in my diet. Through a plant-based lifestyle, I was able to control and eventually reverse my diabetes. However, I had to leave New York City to seek the care of plant-based doctors. I was fortunate to have the means to seek treatment elsewhere; however, this is not something that is easily accessible to most Brooklynites and New Yorkers. Health care should not be a luxury. People who are suffering with nutrition-related chronic diseases should be afforded the same quality of care that I received right here in New York City.

Nearly 30 percent of adults in Brooklyn are obese and 11 percent have diabetes. Chronic, diet-related disease is taking a toll on the health and well-being of Brooklyn residents across the borough. We know that poor nutrition contributes to preventable, diet-related chronic disease, and low-income communities and communities of color are disproportionately affected. Despite an individual's best efforts, the current urban environment often contributes to poor dietary intake with little space to grow fruits and vegetables, limited access to fresh and high-quality ingredients, and an abundance of convenient but poor quality food. As such I am calling for the creation of a plant-based clinic in the H+H system and request the necessary funding for this innovative approach with the potential to change the health of New Yorkers. Establishing this preventive health outlet will provide patients with resources to use diet to prevent and treat chronic disease, a resource that is currently lacking in Brooklyn hospitals.

Its creation builds on my existing healthy eating initiative, which comprises of three primary focus areas: encouraging urban agriculture, improving nutrition, and providing preventive care tools for Brooklynites. Great progress has already been made to support healthy eating and prevention of chronic disease in the borough, and efforts are continuing to be made to develop

and expand sustainable programming to service the needs of Brooklyn's dynamic and growing population. Developing a plant-based clinic in Brooklyn will provide a critical resource for residents looking to adopt a healthier diet and lifestyle.

A plant-based clinic, which can be integrated into an existing health care setting, such as a hospital or an outpatient treatment facility, will provide patients with resources to prevent and treat diet-related disease. Dietary risk, which is avoidable, is the number one cause of death, surpassing smoking. For example, according to a study published in October of 2016 by the JAMA Network titled *Association of Animal and Plant Protein Intake With All-Cause and Cause-Specific Mortality,* replacing processed red meat with plant protein lowers mortality rates by 34 percent. This clinic will assist in reducing the burden of chronic disease in Brooklyn through access to registered dieticians, classes, community groups, and a treatment model of "food as medicine."

Secondly, I would like to reiterate my support to build a burn center in Brooklyn and to request the necessary funding for the creation and operation of this integral component of our health care system. In a borough of 2.6 million people, there are no burn centers within the borders of Brooklyn. As a point of comparison, Chicago, a city with a population roughly equivalent in size to that of Brooklyn, has two burn centers to serve its residents. In 2017, the New York City Fire Department (FDNY) responded to more than 8,000 structural fires and nearly 5,000 non-structural fires in Brooklyn alone, an increase of nearly two percent and 6.5 percent over 2016 statistics, respectively. In December of 2017, Sheepshead Bay suffered a tragedy when the home of the Azam family went up in flames and a mother and her three children perished in the fire. Three surviving family members were transferred to the burn unit in Staten Island. A burn unit in Brooklyn would have decreased transport times and allowed loved ones easier access to visit the victims.

According to the National Institutes of Health (NIH), advancements in health care have dramatically improved outcomes for patients in burn units as hospitals have developed better procedures to close wounds, prevent infection, reduce inflammation, and expedite the process of healing. Victims who once would have died or suffered severe impairment as a result of their burns are now surviving and leading healthy, successful lives. These improved outcomes can be credited to the modern treatments available in burn centers. Modern burn centers not only address burns suffered in fires, but are also integral to treating burns from scalding liquids as well as road burns resulting from pedestrian, cyclist, motorcyclist, and motorist crashes. The creation of a burn center in Brooklyn would ensure high-quality care for Brooklyn residents in cases of such eventualities.

In the wake of a series of particularly tragic and fatal fires in 2015, 2016, and 2017 in Brooklyn, I began a concerted call to build a burn center. I allocated $4,150,000 from my Fiscal Year 2016 (FY16) capital budget to the build-out of a burn unit. However, estimates for the creation of a unit range upward of $8 million to build out and roughly $6 million to operate per year. While my office is committed to fulfilling the capital gap in funding to build out the burn center, we are requesting that the Council allocate $10,000,000 in the Fiscal Year 2019 (FY19) New York City budget to complete the capital and operating costs to help to make this vision a reality. In February 2018, my office, in conjunction with the Brooklyn delegation of the New York City Council, sent a letter to Mayor de Blasio requesting this same allocation of funds. The creation and operation of a burn center will be an invaluable component of our health care system, and we would like to thank the committee for its consideration.

Lastly, our hospital system needs to continue to find means to reduce the overuse of the emergency room. Emergency department overuse leads to higher costs of care, doctor burnout, long wait times and reduced patient outcomes. However, many residents do not have access to a primary care physician, or hours are not available during evening or weekends. Low income and limited access points to health clinics result in the use of the emergency room as the primary source of care for most residents of North and Central Brooklyn. In May of 2017, I launched the "Is it an Emergency" initiative to educate residents as to when they should visit the emergency room, a health clinic, an urgent care, or a primary care physician. In order to decrease unnecessary visits, the hospital system needs a multipronged approach to increase access to quality healthcare for all residents. As NYC Health and Hospitals continues to reorganize, they should take a lead from my initiative and focus efforts on an emergency room diversion program, that will benefit NYC residents, maximize their budget, and allow for better use of their resources.

On behalf of myself and the 2.6 million residents I represent, I thank the Committee on Hospitals for the opportunity to testify today, and I look forward to working with you to ensure the health of our constituents.

Testimony of

Ralph Palladino

2nd Vice President

New York City Clerical-Administrative Employees

Local 1549

DC37, AFSCME, AFL-CIO

before the

New York City Council Hospitals Committee

Hon. Carlina Rivera

Chair

March 15, 2018

Testimony
New York City Council Budget 2018
Hospitals Committee Hearing
Thursday, March 15, 2018
By Ralph Palladino, 2nd Vice President
AFSCME DC 37 Local 1549

New York City Clerical-Administrative Employees Local 1549 represents 5,000 employees of the public New York City Health+Hospitals (NYC H+H). Local 1549 also represents employees of the Metro-Plus HMO run by NYC H+H.

Our members perform financial and revenue raising duties such as patient registration/appointments, financial counseling, record keeping, patient information, medical correspondence, medical translation, billing, communications functions, translation services among other responsibilities. In MetroPlus they register the public for health insurance.

I am an employee and patient at Bellevue Hospital, the country's oldest public hospital. I served as Chairperson of the Local 1549 Hospitals Chapter, representing our members citywide, the Legislative Chair of the Bellevue Community Advisory Board, and DC 37's representative on Governor Spitzer's health care Transition Team. Additionally, I was active in national health care reform efforts.

Patient Care at NYC H+H - The Good

As a patient and/or employee of Bellevue Hospital (NYC H+H's flagship institution) since 1979, I take my health care very seriously, as we all should. Choosing a provider is a quality-of-life, and sometimes life-and-death, decision. My employer-based insurance gave me the opportunity to be a patient in almost any health-care facility in the city. I chose Bellevue. I would not trade my Primary Care Physician for anyone.

In 1985, a massive asthma attack nearly killed me. Bellevue Hospital's emergency-room staff saved my life. The follow-up care and education, at the Bellevue Asthma Clinic headed by Dr. Joan Reibman of the World Trade Center service, resulted in my now only needing the lowest dosage of preventative medicine to control my asthma. As a result, I rarely require the "emergency" medicine, Proventil, or need an emergency-room visit. Excessive Proventil use can put wear and tear on your heart. Because of the care and education of my clinic doctors, I am healthier and safer, while spending considerably less money on medications. I have also used other "specialty" clinics. The care and education I received in all visits, for various ailments, has kept me healthier with rare recurrences of health issues. This includes physical therapy.

There are many thousands of stories like mine about the excellent quality care received at H+H facilities. Councilman Reynoso, a member of the Hospitals Committee was interviewed in the Chief Newspaper two weeks ago about the great care his wife received at Woodhull Center in Brooklyn.

NYC H+H has received countless awards for excellence in the delivery of health care which has never been reported by the press. The NYC H+H MetroPlus constantly receives awards for the "Best HMO in New York State."

Patient Care at NYC H+H- The Not So Good

The biggest problem that NYC H+H facilities have is the lack of access. There are two types of access. One is the number of medical personnel and units available for outpatient care.

The other is access to someone who is able to answer questions and make appointments. Some of the problems associated with making appointments have improved marginally in the last year. But I still must wait three to four months to make my primary care appointment.

Our Metro Plus members say that a big problem in retaining new patients is the long wait to get a first appointment. It takes up to three months. Many patients do not want to wait that long, so very often they just leave the system. This is due to lack of enough Primary Care capacity.

Calling for an appointment could still take up to 20 minutes or more, from the time calling Communications to speaking to a Call Center Representative. Trying to reach a clinic directly to speak to medical personnel is nearly impossible. When I am connected, the phone at times never gets answered.

Upon arriving at a unit for servicing, I could wait for up to two hours to see a physician. This depends on the clinic. At the Primary Care unit, it always takes a while before being called in to see the physician. Lines for registration are long at times but it always takes a while to make a follow up appointment after seeing the physician.

There are waits for simple things like having your blood pressure taken and to having blood drawn. This is due to the lack of staff.

Our members report that waits in Emergency Rooms are long also.

I, and others I know, have experiences with private facilities in New York. I never experienced or heard of these kinds of complaints about them.

The clerical staff answers phones in a timely manner and you can usually reach a clinic. The waits, once there, are not nearly as long.

Lack of staffing and privatization hurts

Patient frustration in waiting for service often leads them to abuse our front line clerical staff. This happens in person and on the phone. Working on the front lines is stressful for our members who have to deal with the complaints about wait times.

Morale is low because of this. Our members feel that no 'higher ups' care about or listen to them. They feel threatened when private temps are hired. NYC H+H is still hiring them.

Having worked and supervised in Ambulatory Care areas, I attribute these problems in part to lack of staffing. Often there are titles other than trained clerical-administrative civil servants sitting in registration areas. There are also private temp agency personnel sitting at the same desks. In one hospital, North Central Bronx, I observed nearly all of the Ambulatory Care registration and appointment duties in certain clinics being performed by private agency personnel. One time there were four agency personnel performing our jobs. This is disturbing given that these private agency personnel have access to our medical record numbers and other confidential information. We think this is a problem given the fluid nature of private temp personnel coming and leaving institutions. There is also a problem of quality and absentee control because of this. It is contradictory to claim that clerical work is not so important and yet have so many private temp agency personnel performing those duties.

It is good to hear that the new head of NYC H+H is eliminating contract consultants. Just recently a consultant decided that work our clerical associates had always performed in Finance needed to be taken over by higher paid personnel. Please note that these job functions have changed at various times and that our clerical associates were always able to perform the duties. They claim the change was needed because the computer work became "more complex" which it did not. They also said it should require someone with college experience to perform the duties.

They made the change and began hiring the same people who were our clerical associates for the positions. The consultant "consulted" by sitting next to the employees and watching them work, while never once asking anyone a question. **This was a waste of NYC H+H and taxpayer dollars. It was a change that never should have happened. This decision should be reversed. (see attached partial listing of grievances filed)**

Union members know best - Listen to us!

We applaud the new leadership of NYC H+H for eliminating or reducing consultant contracting. It is our experience dealing with consultants and their findings is that it is our membership, and others on the front lines who work in the system, are best suited. At Bellevue Hospital, our members participated on a team with others to design the wonderful Emergency Room and later the Ambulatory Care building. We also led the committee in the effort that resulted in the building of the Bellevue Childcare Center that is still in operation.

It was Local 1549 that suggested, over 10 years ago, at the HHC Municipal Labor Committee that all employees of the city be allowed to join the MetroPlus HMO. We also suggested integration of other services and agencies, especially HRA with the SNAP and Medicaid Eligibility Specialists to facilitate better health outcomes. Both of these suggestions were rejected. That is until recently when management realized (later than they should have) that indeed our suggestions had merit.

The Delivery System Reform Incentive Payment Program (DSRIP) workforce and reorganization project is mandated to be a labor-management partnership. It is in reality a process whereby management tells labor what they want to do. Once that happens, it is labor is considered to have been "consulted." This is the same type of "partnership" that NYC H+H has always practiced. Maybe if the process was truly a partnership NYC H+H would be in better shape today.

In recent years we have suggested greater utilization of the Client Navigator title that is responsible for providing all types of information to patients and can provide critical and important face to face interpretation services. (Currently, nearly all interpretation is either by volunteers or phone line private contractors). This title's job description is broad enough to encompass all types of services in one title. But this suggestion, like others, has not been accepted.

Financial Difficulty Inside the NYC H+H

Rather than looking at replacing clerical-administrative staff with higher paid titles the NYC H+H should instead have been looking at the issue of the non-closure of medical visits rates instead. This chronic problem was alleviated for a while at Bellevue Hospital as a result of Local 1549's suggestion that the new MDs and residents coming into training be educated about the importance and methods of closing visits.

Large volumes of paperwork generated by visits not being closed properly are regularly delivered to our members in Finance to make sure they are closed properly. In the past, large amounts of overtime by higher paid non-clerical staff was used for this.

Another problem is that management in the institutions have replaced clerical-administrative employees with most non-civil service and higher paid employees including managers to perform regular clerical duties. THIS HAS LED TO A WASTE OF WELL OVER $1 million a year in NYC H+H and tax payer dollars. There are some higher paid employees in titles that are supposed to be either supervising or handling patients' health care needs, but are

IS THIS? **This wasteful and uneven misuse of titles in NYC H+H needs to end. Employees need to perform the job tasks they were hired for.**

City's Responsibility

In recent years, Local 1549 has been virtually alone in requesting that the city increase its' tax levy commitment to NYC H+H. During the Dinkins' administration, tax levy funding accounted for 33% of H+H's funding.

Mayor Bloomberg's "assistance" for NYC H+H spearheaded by a high paid DeLoitte contract was to put money into the system. But the price was increased by privatization and there was a reduction of staff and services.

Mayor de Blasio is to be thanked for finally putting more tax levy funding into the system. The administration also aggressively has been trying to sign up the uninsured for health insurance. Our Local's members in Metro Plus, H+H and HRA assist with this. The amount of city aid is now at 25% of the NYC H+H budget.

We think more must be done by the city if we are to survive. While the real dollars spent by the city supporting this great public health system is close to what it was under Mayors Dinkins and Koch, the percentages are not. Today, we have a more trying climate (in terms of funding sources, pricing and in our population's health) and a much larger population in the city in need of public health facilities.

The State's Responsibility

The Governor wisely proposed a $1 billion allocation to serve as a buffer for proposed cuts to Medicaid and other health care services by the Trump administration and the Republican controlled congress. As proposed now, state administration officials will be deciding who will get the funding, how much, and what the criteria will be.

Our state elected legislature will have no say in this distribution or the methodology. Since the Governor has vetoed the Safety Net Legislation that would have leveled the playing field between public and private health institutions we think this is problematic.

NYC H+H as a public institution, with an administrative overhead of 3%, is the most efficient deliverer of healthcare in the city. Yet the cost of care is never met since Medicaid reimbursement is under-funded. The cost of care in a clinic was $250 two decades ago while the reimbursement rate was around $90. In the Emergency Room the cost was $350 while the reimbursement rate was about $100. There has been no increase in these rates for 10 years. State Disproportionate Share (DSH) is not distributed based on who deserves to receive the funding (according to the real percentages of where the indigent - including undocumented immigrants and those legally in the U.S. for under five years - go for care). An unequal share of this funding goes to the private so-called not-for-profit institutions whose CEO's make well over a million dollars annually in salaries. Those institutions often have overheads of 20% or more. The "safety net" must be redefined.

Thanks to the ACA more access for health care is required, given that more people have and will continue to become, insured using services. Yet NYC H+H has been reducing staff steadily for the past two and half decades. They have looked at ways to consolidate and cut services that they directly provide due to lack of proper financial support. We welcome Dr. Katz's words on building up revenue rather than cutting staff and services. We hope that he follows up with the elimination of the wasteful and inefficient private contractors as well.

Local 1549 asks of the City Council

- To actively engage the Governor and State Legislature to ensure democratic decision making and fairness for public institutions in receiving the funding they should be receiving the NY State Legislature should also have a say in who receives this "emergency fund" and the methodology for payment. NYC H+H should receive its fair share based on proportion of Medicaid and indigent patients we care for.
- To actively engage the Governor and State Legislature to increase reimbursement rates for Medicaid.
- To seek to increase city tax levy funding for NYC H+H until it has become more solvent. The people in need the most in this city need their public health institution.
- To encourage the use of seeking 1115 and other Wavers for funds to carry on needed and innovative projects since the current administration in Washington claims that state's now have more leeway in health reform and in seeking such wavers.
- To insist that NYC H+H stop wasting tax dollars paying higher paid titles in jobs they were not hired for and cease circumventing the civil service system. This will enhance productivity.
- To cease the continued hiring of private temporary workers to fill positions especially for clerical-administrative duties. This will mean an increase in productivity, efficiency, quality control and better ensure patient confidentiality.
- To encourage NYC H+H join in a genuine, give and take partnership with labor along with the Community Advisory Boards, and Health and other parts of the Advocacy community in redesign of work and the entire system of healthcare delivery.

Thank you!

Clerical-Administrative Employees Local 1549, District Council 37, AFSCME, AFL-CIO

Local 1549 Analysis of Projected Salary Difference Regarding NYC Health + Hospitals Employees in Non-Clerical Titles Performing Clerical Duties in Violation of Article VI, Section 15 of the Clerical Unit Contract For the Period 2012-2017

Titles of Non-Clerical Employees Performing Out-of-Title Duties	Salary Approx.	Clerical Associate	Difference	NYC Health + Hospitals Projected savings
Bio Med Equipment Technician	$43K	$37K	$6K	10 Bio Med Equipment Technician reassigned would save approximately $60,000
Telecommunications Associate I	$47K	**$37K**	**$10K**	10 Telecommunications Associates reassigned would save approximately $100,000
Patient Care Associates	$41K	$37K	$4K	10 Patient Care Associates reassigned would save approximately $40,000.
Health Care Program Planner	$42K	$37K	$5K	10 Health Care Program Planner reassigned would save approximately $50,000.
Sr. Health Care Program Planner Analyst	$41K	$37K	$4K	10 Sr. Health Care Program Planner Analysts reassigned would save approximately $40,000.

Source: Pay Orders. NYS Civil Service Law, Article 61, Section 2: Prohibition against out of tile Work and Clerical Unit Contract: Article VI, Section 15.

Clerical-Administrative Employees Local 1549, District Council 37, AFSCME, AFL-CIO

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Titles of Non-Clerical Employees Performing Out-of-Title Duties	Salary Approx.	Clerical Associate	Difference	NYC Health + Hospitals Projected Savings
Coordinating Manager	$50K	$37K	$13K	10 Coordinating Managers reassigned would save approximately $130,00.
Hospital Care Investigators	$44K	$37K	$7K	10 Hospital Care Investigators reassigned would save approximately $70,000
Assistant Coordinating Manager	$50K	$37K	$13K	10 Coordinating Managers reassigned would save approximately $130,000.
Hospital Police Officer	$49K	$37K	$12K	10 Hospital Police Officers would save approximately $120,000.
Sr. Health Care Program Planner Analyst	$55K	$37K	$18 K	10 Sr. Health Care Program Planner Analysts reassigned would save approximately $180,000.
Community Associate	$41K	$37K	$4K	10 Community Associates reassigned would save approximately $40,000.
Service Aides Housekeeping Aides Institutional Aides	$37K	$37K	0	10 Service Aides Housekeeping Aides reassigned would save approximately $0 but would ensure clerical errors are reduced.

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Testimony of Doctors Council SEIU
Kevin Collins, Executive Director
Before the New York City Council Hospitals Committee
Preliminary Budget Hearing
March 15, 2018

Doctors Council SEIU represents thousands of doctors in the Metropolitan area, including in every NYC Health + Hospitals (H+H) facility, the New York City Department of Health and Mental Hygiene, correctional facilities including Rikers Island, and other New York City agencies.

New York City Health + Hospitals takes care of all New Yorkers, and has historically taken care of the City's poorest and sickest patients. H+H remains the City's single largest provider of healthcare to Medicaid patients.

Our member doctors are committed to ensuring that H+H remains a quality safety-net system for all New Yorkers.

H+H faces financial challenges. As we embark on this chapter in H+H's history, I am reminded of what Doctors Council wrote in a white paper we presented to the City and H+H a few years ago.

We know that there will be continued pressure to cut costs. Even as the Affordable Care Act expanded the number of people who have health insurance, H+H still takes care of large numbers of patients who do not have insurance, especially undocumented immigrants. Rather than be fearful and reactive to this daunting reality, we have an ethical responsibility to embrace this challenge.

Cutting services, consolidations or closing hospitals is not the answer. Privatization or outsourcing is not a solution. These are misguided attempts at the challenges facing us and are abdications of our collective missions to provide quality and affordable care to all New Yorkers.

Dr. Donald Berwick, former administrator of CMS, reminds us that there is a choice to be made: "Chop or Improve. If we permit chopping, I assure you that the chopping block will get very full - first with cuts to the most voiceless and poorest of us, but soon after, to more and more of us. Fewer health insurance benefits, declining access, more out-of-pocket burdens, growing delays. If we don't improve, the cynics win."

Doctors Council SEIU professional members and our leaders will work with H+H and its new CEO Dr. Katz and take a strong leadership role to improve our current delivery system.

We support the focus on clinical positions and agree that H+H can grow itself out of the budget situation by working together. We don't have to shrink to succeed. Doctors are enthusiastic about working together for the good of our patients.

We are pleased that H+H has plans to hire additional physicians so there is more availability and shorter wait times. Patients want our services, and we need to have the staff to be available to see them.

We agree with Dr. Katz that we need to invigorate and expand primary care, improve access to specialty care and implement plans to improve H+H's fiscal situation.

Specifically, we support focusing on clinical positions instead of outside consultants in order to reduce administrative expenses.

We believe the system can successfully provide quality specialized care that meets patients' critical needs while producing revenue.

Importantly, H+H would greatly benefit from recovering more revenue by improving billing and coding practices. We support funding in the proposed executive budget to implement new, advanced revenue cycle technology designed to maximize the amount of revenue H+H collects for the services it delivers.

With respect to correctional health in the Budget, we support increased funding for services to various populations including women, inmates with substance abuse disorders, and LGBTQ youth. Furthermore, we are pleased to hear about proposals for capital improvements and expansion of enhanced pre-arraignment screening units

across several detention houses. Medical clinics across Rikers Island would also benefit from similar physical plant improvements.

H+H must also continue to work to increase the number of patients it serves and to enhance insurance access. We need to think about creative ways to engage with New Yorkers and to bring new patients into the system. We encourage the City to explore synergy between H+H doctors and the DOHMH School Health program and to potentially pilot a program that allows H+H doctors to visit schools. As you may know, there are very few physicians in the School Health program. A pilot could potentially center around one public hospital in a high-needs community with several schools in the vicinity.

We also need to ensure that communities and local stakeholders are engaged in the future of H+H. Doctors Council SEIU has helped launched an innovative labor management partnership in H+H called the Collaboration Councils in an effort to ensure that the thoughtful input of front line doctors are taken into consideration when significant decisions are made, and to increase physician engagement while we work together to improve the patient experience and quality care. Restructuring efforts demand transparency and must include workers and community groups and stakeholders.

Lastly, all of the City's budgetary efforts are greatly affected by Albany and the federal government. The confluence of two factors – (1) DSH funding, which has been in jeopardy in recent years, and (2) the State indigent care pool not sending dollars to the institutions and patients that need it most – places H+H in jeopardy. The money should follow the patient and funding intended for health systems such as H+H, who care for the uninsured and Medicaid patient population, should go to the health systems that see these patients. We ask our Council Members and City Hall to recognize these disparities and especially to call on the Governor to create a more equitable state funding formula in the State Budget by ensuring that resources go where they are needed the most and to those that provide the care.

Thank you for the opportunity to submit this testimony.

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PRELIMINARY BUDGET HEARING ON HOSPITALS
NEW YORK CITY COUNCIL

Testimony of the New York Immigration Coalition
Presented by Claudia Calhoon, Director of Health Policy

March 15, 2018

Good afternoon. My name is Claudia Calhoon, and I am the Health Policy Director at the New York Immigration Coalition. I would like to start by thanking Councilmember Carlina Rivera for her long track record of work in support of health equity and for convening this hearing. We are pleased that there is a committee dedicated to hospital services during this time of extraordinary change within our health care system. Although our comments today are focused on New York City Health and Hospitals (H+H) system, we look forward to working with you to ensure that all hospitals, both public and voluntary, act to benefit immigrant patients and communities.

The NYIC is an advocacy and policy umbrella organization for more than 200 multi-ethnic, multi-racial, and multi-sector groups across the state working with immigrants and refugees. The NYIC Health Policy program and Health Collaborative bring together immigrant-serving organizations and other stakeholders from the frontlines of the battle to improve health access.

We are grateful for the opportunity to discuss New York City hospitals and immigrant health care as part of the budget process. New York City H+H is a valued partner in extending health care to immigrant communities across the city. Shortly after the presidential election, H+H's Open Letter to Immigrants[1] and a series of community forums to reassure patients about the safety and security of seeking health services were important first steps in counteracting misinformation and fears of patients. Importantly, no other hospital system in New York has undertaken a similar campaign to educate their patients about the safety and security of using health services. Ongoing and sustained efforts from across the health system are necessary to make sure this information continues to reach patients. H+H provides unparalleled access to affordable care for New Yorkers regardless of their insurance status. The H+H Options program makes fee-scaled, affordable services available to individuals earning up to 400% of the federal poverty level.

The NYIC advocates to city and state partners for resources and support for H+H and for its

[1] https://www.nychealthandhospitals.org/wp-content/uploads/2016/12/immigrantCampaign_LetterFlyer.pdf

immigrant patients. We also advocate to H+H on behalf of immigrant communities to address shortcomings in its services for immigrants. There has been extensive discussion across the city and in the media of the fiscal challenges faced by H+H. Despite the fact that it provides the bulk of services to the city's uninsured population, H+H faces periodic threats of reductions in federal funding from Affordable Care Act cuts to Disproportionate Hospital Share (DSH) funding. It is also hampered by a process for distributing New York State Indigent Care Pool funds that favors other health care providers. A recent report from the New York State Nurses Association highlights the fact that H+H's fiscal challenges are not related to inappropriate expenses or services, but to insufficient revenue that does not fully value its provision of level I trauma care, behavioral health services, and care to low-income and uninsured patients within the city's overall health care system.[2] H+H's assumption of those functions allows other hospital systems in New York City to operate profitably, while H+H is constrained by crippling budget deficits.

We have said in this setting that we hope the city will incorporate this perspective into its planning to restructure H+H services. It would be devastating for immigrant communities if changes to H+H were only undertaken through sharp contractions of services and sites, without addressing the broader financing inequities that created the current situation. We also urge H+H and New York City to ensure that transformation efforts include a mechanism for community input on major decisions.

Closing Gaps and Addressing Resource Needs

Having sufficient resources is especially important to address the challenges that immigrant patients report when they use H+H services. Last year we shared with our partners at H+H a memo summarizing focus groups that we conducted on perceptions of H+H services among Korean speakers in Flushing, Spanish speakers on Staten Island, and French-speaking West Africans in East Harlem and the Bronx. Numerous cross cutting themes emerged from these distinct groups, including affordability of services, lack of courtesy and a welcoming attitude, the persistence of language access barriers, waiting times, the difficulty of making appointments by phone, travel time and costs, and the importance of access to primary, specialty, and behavioral health care. Although some time has passed since we convened these communities, we know from our member organizations these issues persist. The entire memo is submitted along with our testimony.

Cultural competence and having an opportunity to see a physician with whom one feels comfortable was of primary importance to the individuals that participated in our groups. One Korean speaking gentleman from Flushing noted, "What's the point of going to a hospital when I'm sick, when it will stress me out? I would rather go to a Korean doctor, ***even though I know he***

[2] https://www.nysna.org/sites/default/files/attach/419/2017/09/RestructuringH%2BH_Final.pdf

cannot treat the issue. At least I will have a more comfortable experience."

Participants in all three groups noted that seeking mental health services is difficult logistically, fraught with stigma and misconceptions, and critically important for their community. The experience of being an immigrant, the conditions under which individuals came to this country (such as having crossed the border) make the availability of mental health services critical for their communities. As one women noted, "We joke about being crazy but [we] really do see bad effects in their friends and families.... Sometimes it's not apparent that people have lived through really horrible things, but they still need help."

NYIC also participated as key informants in H+H's own evaluation of its Options program in 2016. That evaluation aimed to identify ways to improve the design and administration of the fee scale program. But that evaluation found that just as important as designing a fee-scale program with features that made it easy to enroll and use was improving the experience of patients in receiving health care, particularly for immigrant patients. This included improving language access, reducing stigma of being uninsured, and addressing the frequent negative patient experiences associated with being an immigrant.[3]

ActionHealth NYC

One important program that H+H undertook to address many of these challenges was the ActionHealthNYC pilot. This demonstration project was the major initiative to emerge from the 2014-15 Mayor's Taskforce on Immigrant Health Access.[4] ActionHealthNYC tested important innovations in improving health access and continuity for immigrants excluded from federally funded insurance programs, including enrolling individuals in a branded program designed to link patients to a primary care provider, linking services at H+H to federally-qualified health centers, and ensuring that care coordination prevents patients from dropping through the cracks. News reports documented the fact that the evaluation showed that ActionHealthNYC enrollees were more likely to receive a host of preventive services including hypertension, diabetes, weight, cholesterol, tobacco use, depression, colorectal cancer, and HIV screenings as well as influenza vaccinations as compared to a control group.[5] Thirty-seven percent of those in ActionHealthNYC saw a specialist compared with 13 percent in the control group.[6] The group that participated in the pilot was also more likely to receive a diagnosis of a chronic condition, including mental health diagnoses than the group not offered the intervention. Participants reported that the program made it easier to get health care

[3] Romero D, Flandrick K. A Focus Group and Key Informant Interview Study of Experience with the NYC Health & Hospitals Options Program. December 8, 2016.

[4] http://www1.nyc.gov/nyc-resources/task-force-on-immigrant-health.page

[5] https://www.politicopro.com/states/new-york/city-hall/story/2018/03/02/report-actionhealthnyc-shuttered-program-for-immigrants-produced-positive-outcomes-291101.

[6] https://www.politicopro.com/states/new-york/city-hall/story/2018/03/02/report-actionhealthnyc-shuttered-program-for-immigrants-produced-positive-outcomes-291101.

when they needed it. The program made health care more friendly, accessible, and less chaotic for participants.

The NYIC served on several workgroups of the Mayor's Taskforce on Immigrant Health Access, and contributed substantially to the conversations with city partners that designed the pilot. We were also part of the Community Advisory Panel for ActionHealthNYC. Several of our member organizations were among those that undertook community outreach to participants.

We are disappointed that the ActionHealth NYC pilot was discontinued without a concrete plan to incorporate lessons learned and grow an uninsured care program that reaches a broader number of undocumented New Yorkers. Extraordinary time and effort was invested in assessing the needs of the immigrant community for improved health access, in designing and measuring the impact of the program, and executing the program across H+H and participating health center sites. We have heard from our partners in the administration that the city will be applying some of the lessons of the pilot to an initiative to target the patient population that use Emergency Departments the most. While this is a laudable goal, this focus on the sickest population overlooks the broader goal of facilitating access to primary, specialty and behavioral care for a broad spectrum of the immigrant community who depend on services at H+H. The ActionHealthNYC pilot serves as an actionable template for improving the patient experience for the uninsured. The program's evaluation suggests that implementing such a program will also improve population health for H+H patients, which will in turn make the system work better for all patients.

We strongly urge the city to ensure that lessons of ActionHealth NYC are be incorporated into H+H's fee-scale Options program or to some other initiative. Linking individuals to genuine primary care homes, improved access to primary and specialty care, care coordination, and leveraging participation of partners outside H+H such as community health centers are all features of the ActionHealthNYC pilot with extraordinary value. We look forward to working with H+H and city partners to improve immigrant health access and outcomes.

Thank you for calling this hearing and for providing me the opportunity to share this testimony today.

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MEMORANDUM

New York Immigration Coalition Community Engagement Sessions

December 26, 2016

As part of New York City Health + Hospitals (H+H)'s community engagement for transformation efforts, the New York Immigration Coalition (NYIC) conducted community engagement sessions with three of its members during November and December 2016. The sessions took place November 29 at Korean Community Services (KCS), December 7 at La Colmena Community Job Center, and December 8 with African Communities Together (held at Hostos Community College.) The sessions were facilitated by Claudia Calhoon and Max Hadler from the NYIC, with critical support from staff members of host organizations. Fourteen people attended the session at KCS, 15 attended the session at La Colmena, and 17 participants were present for the ACT session as Hostos Community College. Host organizations served a meal to participants. KCS and ACT also offered participants incentives for participation.

NYIC staff began by distributing the H+H survey developed by Community Resource Exchange (CRE) for the larger community forums planned during the same time frame by CRE. NYIC and member organization staff assisted participants in completing the surveys. NYIC provided initial framing comments on pending changes planned for H+H. We noted that these sessions are designed to solicit feedback on what H+H can do to improve services across the city as part of this restructuring. NYIC noted that it did not represent H+H, and assured participants that all information shared would be anonymous. We requested permission to record the session, and stated that recordings would be deleted once the data has been analyzed. The NYIC led all discussions using the attached conversation guide. The event at KCS was conducted with consecutive interpretation in Korean and English, the event at La Colmena was conducted entirely in Spanish, and the ACT event was conducted with simultaneous interpretation in French and English.

Despite the geographic and ethnic diversity of the three populations that participated, numerous cross cutting themes emerged. This memorandum is organized around critical areas of concern that all participants shared.

Affordability

Participants in the Korean and Spanish-speaking group noted that they use H+H services because they are more likely to be affordable than other providers. All participants noted that using health care, even when it is structured on a sliding scale, may prompt financial challenges, and require patients to choose between seeing a doctor and paying other bills. French-speaking participants indicated that for undocumented populations, even with H+H fee-scaling, some services and procedures still remain out of reach financially. All groups noted confusion about how to deal with high medical bills, the availability of health insurance for some immigrant populations, Emergency Medicaid for undocumented individuals, and financial supports like

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New York State's Financial Assistance Law. As participants from the Staten Island group noted, "la información no está afuera, está adentro," or "the information is inside the hospital, not outside."

Lack of courtesy and welcome

A consistent critique voiced by all three groups was the lack of courtesy, helpfulness, and warmth from H+H staff at all levels. Frontline staff who greet patients are reported as being frequently rude or unfriendly. Administrative staff who make appointments are unhelpful and appear unfamiliar with cultural considerations important for participants from all groups. One woman in the KCS group asked whether immigrants are treated this way because the staff looks down on them. It was also noted that in visits, physicians themselves appear rushed and may tend to look only at the electronic health record and not at the patient. Participants noted that when doctors are not interacting with them or communicating with the patient directly it makes going to the doctor feel like an assembly line. Several people noted that physicians do not always explain medication regimens, potential side effects, treatment decisions, or why they are drawing blood or taking urine samples. Patients who are undocumented tend to interpret this lack of communication as being related to their status. As one person reflected, "A lot of our immigrants are undocumented, [and] the condescending attitude from the providers creates a trust issue." While very serious issues are raised about courtesy and the quality of the patient experience, it was noted in at least two cases that participants had positive experiences at H+H Bellevue and Morrisania Health Center in the Bronx.

Language Barriers

All groups reported instances of tremendous difficulty with language access at H+H. This included not being informed that they were entitled to interpretation, not having access to interpretation when calling to make appointments, difficulty of getting an interpreter when seeing a specialist, and gaps in particular languages, including Korean. Language access for the Korean community was a particularly emotional recurrent theme in the KCS group. Several people in the Flushing group perceived that much better accommodations are made for Chinese and Spanish speakers at Elmhurst than for Korean speakers. Korean participants laughed when asked them if anyone had ever had a good experience with language access. One woman reported being told by Elmhurst hospital staff that the Korean population was too small to merit having in-person interpreters. Korean speakers emphasized the degree to which accessing health care without interpretation increases the stress of accessing health services. Language access issues appear to drive Korean speakers with insurance to seek care from neighborhood practices owned by Korean physicians. As one gentleman noted, "What's the point of going to a hospital when I'm sick, when it will stress me out? I would rather go to a Korean doctor, even though I know he cannot treat the issue. At least I will have a more comfortable experience." The KCS group expressed strong interest in reassurance that they can receive equal access to services even if they can't speak English.

Language access issues were also prominent in the other groups. In the French-speaking group noted that telephonic interpreters do not offer services in groups including Soninke, Fulani, and Moré (Burkina Faso). They also noted that in-person French interpreters are not trained to

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employ a neutral, understandable French (i.e. Haitian interpreters may be difficult for West African patients to understand.) Spanish speakers noted that H+H is doing better with language interpretation than voluntary hospitals on Staten Island, but still note challenges with language access in certain settings, such as behavioral and specialty services. Some participants reported just using hand gestures and trying to get by without interpretation.

Waiting Times

Waiting times, both to get appointments, and to see a health care provider on site were noted by all three groups as one of the biggest complaints. In one case waiting times were described for one person as being so "horrible that they wouldn't go back there again." Getting appointments with primary care doctors or OB/GYN providers can take several weeks or months. Some patients reported difficulty getting through to a phone number to make an appointment to begin with, needing to make appointments in person in order to secure one, and particular difficulty making specialty appointments. Religious considerations can also delay the ability to get an appointment with an OB/GYN. If Muslim women request an appointment with a woman provider, it delays the appointment for even longer. A Korean speaker reported having a kidney stone and calling to make an appointment but the phone continually hanging up on him.

Once patients arrive for their appointment, they are also subject to delays. Patients in both the Korean and the West African groups noted that even when they have an appointment, they frequently have to wait several hours. This was particularly confusing for individuals from Korea where patients are more typically seen on a first-come first-served basis. As one participant asked, "What's the point of appointments if we have to wait so long anyway?" Patients in Staten Island noted that the loss of income from a day spent waiting to see the doctor way surpass the savings offered by H+H's fee scale. Wait times at Mariner's Harbor were reported to have recently improved. But these improvements are at a site where follow up is at Coney Island Hospital, suggesting that accessing health care can still be cumbersome and time consuming. French and Korean speakers also noted extremely long wait times at both Elmhurst and Lincoln Hospitals.

Cultural Competence

The need for health care providers at all levels to have a basic familiarity with the populations they serve was prominent in all three conversations, but appeared to be especially important among Korean and French speakers. Patients typically do not have access to frontline staff or providers that represent their communities or who understand cultural considerations relevant to each community. Patients in the Korean-speaking group indicated that they would prefer to see Korean-speaking providers than see a doctor in a hospital ambulatory setting, and individuals with insurance tend to seek primary care in neighborhood practices. Patients noted that there were no longer Korean providers at Elmhurst, although there used to be. The need for social workers with some basic understanding of the community was also noted.

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Access to Primary Care

All groups endorsed the importance of seeing a primary care provider on a regular basis for regular check-ups, and expressed a strong preference for being able to see the same doctor on a regular basis. Staten Island participants noted that they like to seek care at the Community Health Center of Richmond because it's close by, affordable, welcoming to immigrants, and because patients have had good experiences. While one woman noted the importance of not being locked in to a relationship with a provider that is not a good fit, in general, patients would like to have a single provider that they see regularly. Patients noted that it can take as long as two months to get a primary care appointment at H+H facilities. In visits with they are often called upon to repeat their medical history to new providers who do not appear to coordinate or share information with previous providers. Concerns about wait times were echoed here, as patients reported being offered a choice between a visit with an unknown provider or a longer wait for their established one. Access to a regular primary care provider was noted as being part of getting referrals to specialists. Another area of primary care key need are access to dental services, which can be very costly or hard to get.

Travel time and cost

Proximity is important to patients. It was noted by the Korean speaking group as being among the most important factors to them in selecting their health care. French speaking participants identified the unpredictability of being able to receive Metrocards, depending on which carrier they have for Medicaid Managed care, or whether they have insurance at all, as a critical stress generated by visits to H+H sites. In contrast, the transport from Mariner's Harbor to Coney Island Hospital was noted as working relatively well.

Access to Specialty Care

The ability to access care from a specialist, especially in the case of serious illness, was a prominent concern among all three groups. Participants noted that it is easier to get a referral to a specialist if you go through the Emergency Room, or if you have a regular primary care provider. Patients also noted that co-location of primary and specialty care is especially welcome, as navigating large hospital settings like Lincoln can make accessing specialty care overwhelming. Insured patients who are subject to gated plans requiring a visit with a primary care provider in order to get a specialty care appointment noted the financial burden of the additional co-pay for the primary care visit. Patients who are undocumented expressed a particular concerns about vulnerability in the face of serious illness. This echoed concerns noted above about the fee-scale costs of procedures and surgeries.

Access to Behavioral Health

This was an area of tremendous concern and need for participants of all three groups, and generated a lot of emotion and feedback. Participants in all three groups noted that seeking mental health services is difficult logistically, fraught with stigma and misconceptions, and critically important for their community. As one women noted, "We joke about being crazy but [we] really do see bad effects in their friends and families.... Sometimes it's not apparent that people have lived through really horrible things, but they still need help." Participants noted that

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the experience of being an immigrant, the conditions under which individuals came to this country (such as having crossed the border) make the availability of mental health services critical for their communities. "Just the act of coming to this country across the border affects you," noted one woman in Spanish. Stigma, discomfort, and concern about consequences of being considered "crazy" (particularly for parents) make education about mental health critical for communities affected by economic stress, dislocation, isolation, and discrimination. It was noted that patients do not take the time to focus on their emotional health, and need support to cope with stress of navigating life in New York. Domestic violence and substance abuse were noted as concerns by at least one group as requiring behavioral intervention and support. Patients need to be assured that using behavioral health services won't lead to stigmatization or discrimination in the future.

Although one person in a diabetes prevention program had been referred to psychological supports, in general access to behavioral services is limited. Primary care clinics don't tend offer behavioral health services or provide referrals to psychologists. Participants noted the need for increased access to services, ideally that are co-located with primary care services. Education on behavioral health that destigmatizes mental health challenges are key. Among the suggestions for doing this were framing these services as health with stressors of daily life in New York, as opposed to treatment for "craziness." French speaking participants noted that the use of chaplain services in outpatient settings, and having imams available, might create a bridge to facilitate use of other behavioral health services. All groups noted that shortage and importance of social workers, another type of provider equipped to provide behavioral health services in a comfortable, less stigmatizing way.

All participants noted that issues of language access and cultural competence become even more critical for provision of behavioral health services, as trust, confidence, and the ability to be understood are critical for successful behavioral health services.

Care coordination and general navigability

The difficulty of navigating H+H institutions was a frequent topic of conversation. Elmhurst hospital was noted in particular as being overcrowded, lacking helpful signage, disorganized, stressful, and difficult to navigate. Lincoln Hospital was also described as being confusing and chaotic.

It appears possible that the difficulty of navigating Elmhurst created an opportunity for fraud. A Korean gentleman reported having paid $100 to someone who advertised free insurance in a Korean language publication and then assisted him in getting him a clinic card and navigating the hospital. The fact that he felt like it was money well spent highlights not only the difficulty of getting around in Elmhurst, but the level of need felt by patients that depend on its services.

Calling to make appointments is noted as a frequent area of difficulty. People get hung up on, left on hold for 30 minutes or more, or sometimes no one answers the phone. While some patients noted better success making appointments in person, others noted difficulty in doing so.

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Patients also reported losing their appointment because they failed to confirm in advance, without having been told this was required. "If you don't confirm, another person on the wait list gets your slot," one woman reported. Korean speakers reported instances of people calling repeatedly to find out about services but eventually giving up because they aren't able to get through to someone who can answer their questions. As noted above, translation for phone calls into Korean make getting information and appointments especially challenging.

Suggestions for making H+H facilities more navigable included having a point person at a welcome desk to help navigate the facility and distributing a checklist of available services and resources. Offering point of contact so that patients know who to raise concerns with would give patients more recourse when they get stuck.

Need for Information Dissemination about Services, Financial Protections, and Preventive Services

Although we did not ask about this explicitly, a need noted in each group was the importance of information dissemination to communities who are not familiar with H+H services and fee-scale as well as other New York State and City protections and resources. Spanish-speaking participants noted that the information is only available to people who access services in the hospital. Those who don't make their way there, especially those who are undocumented, have no way of learning about the availability of low-cost health care, Emergency Medicaid, language access protections, and financial protections. Participants noted that the best settings for outreach and education are community-based organizations and churches.[1] Finally, participants in both the French and Spanish group noted the importance of health education on preventative care topics: managing chronic illnesses, preventing chronic illnesses, food and health management.

"One thing that H+H can do to make health better"

The last question for each group is what H+H can do to make health care better. All three groups shared enthusiastic and thoughtful responses about their priorities. Rather than summarize, each groups list of recommendations are bulleted below.

Korean Community Services

- Hire more Korean doctors and nurses
- Address language barriers (endorsed multiple times)
- Reduce hold times when people call to make appointments (endorsed multiple times)
- Believes the problem can be solved if the city supports H+H with a bigger budget
- Remember that for undocumented people and immigrants there's no choice other than city hospitals.
- Make health facilities more comfortable and have more supportive staff (endorsed multiple times)

[1] As many city stakeholders know, the NYIC has invested deeply in this work through our advocacy and participation in the NYC Council-funded Access Health NYC initiative and would be eager to discuss ways to leverage that network of awardees to address this need.

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La Colmena

- Offer all services, including dental and mental health services in one place (endorsed multiple times)
- Hire more interpreters and make all services available in Spanish
- Hire more experienced doctors
- Provide access to mental health services that is language accessible and culturally competent; address hidden trauma and keep people from getting to extremes (endorsed multiple times)
- Provide more information about what help and services are offered
- Ensure polite treatment, be fair to immigrants
- Provide a place to go to get information
- Quality care—not just a superficial overview
- Ensure that better help available is over the phone
- Hold health fairs for people to know what's out there

African Communities Together

- Listen!
- Hire interpreters
- Train healthcare workers on the population they are serving, cultural differences, etc.
- Be friendly with patients
- Ensure the doctor can understand what patients are there for, and ensure patients can understand what they're saying (interpretation)
- Do preventative education on managing chronic illnesses, preventing chronic illnesses, food and health management
- Hire more staff, especially social workers. If they are going to develop new programs, they need to hire staff for them.
- Provider easy access to resources.
- Increase cultural competency training for hospital staff & employing those from the surrounding neighborhood.

As noted in previous conversations, we anticipate putting together an outward facing report that includes a fully developed set of recommendations emerging from this event. In the meantime, we are eager to work with H+H to determine how the systems transformation can address the critical issues highlighted in these conversations.

Testimony of Andrea Bowen before the Committee on Hospitals
Transgender and Gender Non-Conforming (TGNC) funding needs in FY19
March 15, 2018

Good afternoon, Chair Rivera. My name is Andrea Bowen, and I'm a consultant working on behalf of what is informally known as the Transgender and Gender Nonconforming (TGNC) Solutions Coalition, which includes the Anti-Violence Project, the Audre Lorde Project, GMHC, the LGBT Community Center, Make the Road New York, Sylvia Rivera Law Project, and the TransLatina Network. These organizations are working in concert to advocate for a series of policy and budget items that, if funded, will improve the lives of the transgender and gender-nonconforming (TGNC) community.

Starting in 2015, these organizations, alongside TGNC community members across the City, organized forums for TGNC people in each of the five boroughs of New York City, following encouragement from New York City Council Speaker Melissa Mark-Viverito, and the Lesbian, Gay, Bisexual, and Transgender (LGBT) Caucus of the New York City Council. Five forums were held over the course of a year and a half with 591 participants. While the City government has done much to support TGNC people, greater work and community consultation is needed to identify remaining problems and potential solutions.

Last November, the aforementioned organizations released *Solutions Out of Struggle and Survival*, a brief on policy and budget items drawn from the recommendations of the community forums, bringing attention to TGNC community needs in the areas of education, employment, healthcare, housing, immigration, and policing and violence.

From the many recommendations outlined in *Solutions Out of Struggle and Survival*, we recommend that several receive funding in the FY19 budget of the City of New York. We have presented versions of these proposals to staff in City agencies, but we seek City Council support to put these items in the budget if the Mayor does not. If Council adds this funding, we ask that Council provide this money to agencies in the Adopted Budget, and the agencies will engage in procurement. Regardless of who funds these programs, we want TGNC community members assisting in crafting and reviewing procurements. I will include at the end of this written testimony our complete collection of budget asks, but I will focus on our asks relating to the Committee on Hospitals' purview in this testimony.

TGNC Healthcare Liaison Program
Proposed Agencies: HHC and DOHMH
Proposed Cost: $820,000

TGNC people are increasingly receiving attention, in terms of specific care and culturally competent care, from the health care industry. However, as community members have made clear in community forums, it is still a struggle for TGNC people to understand how to make connections between health insurance and care providers, arrange appropriate aftercare, and more. Care for TGNC people is more than just providing TGNC-specific care: it means helping the underresourced community find their way around complex healthcare systems.

The struggle for TGNC New Yorkers in accessing quality, affirming, and affordable healthcare is also borne out by statistics. In a 2015 health and human services survey, 15.8% of TGNC NYC respondents reported fair

or poor health compared with 9.6% of cisgender LGB respondents, and 25% of TGNC NYC respondents reported probable depression compared to 15.7% of cisgender LGB respondents. While insurance carriers are required to cover transition-related care in New York State, TGNC people can still experience unjust denials, restrictions, and discrimination when seeking care. In other words, TGNC people are still having trouble attaining full coverage for transition-related care.

We have proposed that HHC and DOHMH work together on a project at a cost of $820,000 to fund seven staff at city hospitals that can act as case managers and advocates for TGNC patients, to help enforce peoples' rights within the health care system, and make sure every part of their care team is in communication to make the best possible health care outcomes. The TGNC Healthcare Liaisons should also work on issues that are not TGNC-specific, e.g., diabetes, pulmonary care, etc. This funding should also include an extra $50,000 for advertising the service to the community.

Funding for this program should be baselined so training can expand and staff can be retained through at least four years.

We appreciate your attention to this issue. If you would like to discuss it further, you can contact me at andy@bowenpublicaffairs.com or 917-765-3014.

SOLUTIONS
Out of Struggle and Survival

Expanded-upon policy and budget solutions for transgender and gender non-conforming (TGNC) New Yorkers
March 7, 2018

After our brief on policy and budget solutions for TGNC New Yorkers, *Solutions Out of Struggle and Survival (available at avp.org/solutions)*, we—a coalition composed of the Anti-Violence Project, the Audre Lorde Project, GMHC, the LGBT Community Center, Make the Road New York, Sylvia Rivera Law Project, and the TransLatina Network—have focused on 6 proposals that we want to focus on funding in the FY19 budget of the City of New York. We have presented versions of these proposals to staff in City agencies, but we seek City Council support to put these items in the budget. If Council adds this funding, we ask that Council provide this money to agencies in the Adopted Budget, and the agencies will engage in procurement. Furthermore, we want TGNC community members assisting in crafting and reviewing procurements.

TGNC Employment Program **Proposed Agencies: DYCD and HRA** **Proposed Cost: $6.46m**
Funding for a program that can work with TGNC youth and adults (in separate cohorts, given unique needs of both populations) and prepare them for careers. Staff will connect program participants to employment programs or job openings. Staff will also provide orientation on soft skills needed in the employment field, orientation on issues that are specific to TGNC people when in jobs, and cultivation of employers and other employment programs that are safe and affirming referrals for TGNC people seeking employment. Staff will have to act as advocates for TGNC people in navigating jobs, ensuring nondiscrimination, and creating safe work environments. Funding includes $1.83m for staffing (which can be broken into a staff for the youth program and a staff for the adult program), $4.4m for subsidized wages, $183,000 for evaluation, and $50,000 for advertising. There must be a TGNC community consultation process to review responses to RFPs for this program, and preference should be given in awards to smaller organizations that can demonstrate a long-standing connection to the community.

TGNC Rental Assistance Program Pilot **Proposed Agency: HRA** **Proposed Cost: $4.1m**
A pilot to provide a special rental assistance program for TGNC people, given the community's disproportionately high homeless rates. This would pay for 200 TGNC people to use a special category of rental assistance focused on TGNC people, and it would also pay for 20 case managers to help participants find housing, deal with any potential discrimination issues that may arise with landlords, and assist with other wraparound needs. Outyear costs may be modified in line with demand for the program.

TGNC Immigration Lawyer Training **Proposed Agency: MOIA** **Proposed Cost: $100,000**
Funding for a pilot number of 5 non-profits (with grants of approximately $20,000 each) to conduct training, geared for immigration attorneys, that educates about TGNC people and the means of attaining specialized visas (e.g., U Visas, which are for survivors of crimes that inflicted physical or mental abuse) that are most useful in helping undocumented TGNC people maintain safe residence in the US.

TGNC Immigration Lawyer Staffing **Proposed Agencies: MOIA and HRA** **Proposed Cost: $715,000**
Funding for 5 non-profits (each receiving $143,000 to cover wage, fringe, and overhead costs of hiring one attorney) to hire lawyers that are knowledgeable of both the visas that TGNC undocumented people need, and TGNC community needs. Grants should be made to cover the cost of a staff member.

TGNC Healthcare Liaison Program **Proposed Agencies: HHC and DOHMH** **Proposed Cost: $820,000**
Funding for staff at city hospitals that can act as case managers and advocates for TGNC patients, to help enforce peoples' rights within the health care system and make sure every part of their care team is in communication to make the best possible health care outcomes. The TGNC Healthcare Liaisons should also work on issues that are not TGNC-specific, e.g., diabetes, pulmonary care, etc. This should also include an extra $50,000 for advertising the service to the community.

Training/Evaluation on NYPD/TGNC Community Issues **Proposed Agency: CCRB** **Proposed Cost: $50,000**
TGNC organizations should once again take part in the training process of NYPD officers, and make changes to NYPD training as soon as possible. Furthermore, funding should be provided for an evaluation of this new training with TGNC-led organizations taking a major role in the evaluation process ($25,000), and $25,000 should be provided to community organizations to inform the TGNC community about *their* rights in interactions with police.

TAG

Treatment Action Group

Hospital Committee Preliminary Budget Hearing:
Testimony on TB's impact on New York City Hospitals
March 15, 2018

Thank you to the Health Committee members for your commitment to making New York a healthier, more equitable place, and for the opportunity to call your attention to the growing threat of tuberculosis (TB) in New York City.

My name is Erica Lessem, and I'm from Treatment Action Group (TAG). TAG is an independent, activist and community-based research and policy think tank fighting for better treatment, prevention, a vaccine, and a cure for HIV, TB, and hepatitis C.

We at TAG, and our partners representing immigrant communities, housing rights, and public health expertise, are alarmed by TB's recent rise in New York. TB is airborne and infectious, meaning anyone who breathes is at risk of contracting this potentially deadly disease. But TB disproportionately affects the most vulnerable: those with weakened immune systems, people living in crowded settings, and our immigrant communities.

Despite being preventable and curable, **TB is on the rise in New York City** for the first time in over twenty-five years. Also increasing at a rapid pace are cases of drug-resistant TB, which are more difficult and costly to treat: a single average case of drug-resistant TB costs $294,000. This resurgence of TB is a direct result of years of underinvestment in New York City's TB response. While in recent years the City, thanks to your leadership, has steadily funded TB, a history of cuts since 2007 have reduced the City's TB funding from $16.43M in 2007 (adjusted for inflation) to just $8.59 million this year. Ongoing reductions at the state and federal levels over the past decade, and dramatic cuts in recent years, have exacerbated this situation. Total funding for the New York City Department of Health and Mental Hygiene (DOHMH) Bureau of TB Control (BTBC) has been reduced by half in the last ten years. Several of the City's TB clinics have closed, and the few that are still open have much more limited hours and staffing.

TB's impact on New York City's hospitals

We are concerned that, as a result of limited funding for TB, the ability to conduct outreach activities, prevent TB, and efficiently coordinate care between the BTBC and New York City hospitals is limited. The failure to adequately fund a TB response places a large burden on New York City hospitals, in addition to causing preventable suffering.

The majority of TB cases in New York City are first identified in hospitals. This means that we are failing to find TB earlier in our communities, to treat it before people become very sick and require hospitalization, and to provide preventive therapy to stop TB from developing in those who are infected, but not yet sick. It also means that when people do have symptoms, they are seeking care in hospitals rather than the City's

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chest clinics. This is in part because so few chest clinics remain (just four, two of which are part-time), and there is not widespread awareness about them.

Once in hospitals, people whose TB is infectious must be placed in expensive isolation wards to keep the disease from spreading. Over half of New Yorkers with TB are uninsured, which places an even greater financial burden on our hospitals.

People hospitalized for TB also require evaluations upon diagnosis and prior to discharge from the hospital to review their chart and medicines, assess if their home environment is safe to return to, and identify any close contacts needing testing for TB infection or disease. But the number of DOHMH public health advisors who can conduct these evaluations has been reduced because of budget cuts, and facing further reductions. This could mean patients having to stay longer in hospitals simply because they can't be evaluated in time for their planned discharge. Reduced clinic hours, especially the loss of Saturday clinic hours, may also mean patients who would otherwise be ready to leave the hospital on a Friday have to stay extra days in hospitals over weekends to ensure coordination of care.

Investing in the public health response to TB now will save billions

Adequate funding for the TB response would lift a heavy burden off of New Yorkers and our hospitals. Increased funding would allow for active outreach by community organizations to raise awareness about TB, and provide services to identify and prevent it, preventing hospitalizations in the first place. It would allow for restored clinic facilities that meet patient needs, so people can seek care in chest clinics instead of having to be hospitalized. And for those who are hospitalized, increased funding would allow for better coordinated care and a faster transition from hospital- to community-based care.

These efforts could save the City billions of dollars. Similar to what we're seeing today, budget cuts in the 1970s and 1980s dissembled the public health response to TB, and led to a massive outbreak of drug-resistant TB in New York City. This outbreak cost over $1 billion to control in the 1990s. This is the first time since then that TB is on the rise again. We are in danger of repeating history, and of overburdening our hospital systems with an epidemic that could be entirely prevented. We are putting our already vulnerable communities, especially immigrants, at great risk.

I enclose a letter from dozens of your constituents appealing for **a restoration of New York City funding to the DOHMH BTBC to $14.89 million** (a $6.3 million dollar increase over the current year). We are making similar—though proportionally higher—requests at the state and federal levels. We look forward to your leadership.

Erica Lessem, MPH Deputy Executive Director – TB, Treatment Action Group
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To: Mayor Bill de Blasio, New York City
Speaker Corey Johnson, New York City Council
Council Member Alicka Ampry-Samuel
Council Member Inez Barron, Member of the Committee on Health
Council Member Margaret Chin, co-Vice Chair of the Black, Latino/a, and Asian Caucus
Council Member Robert E. Cornegy Jr.
Council Member Laurie Cumbo
Council Member Daniel Dromm
Council Member Rafael L. Espinal Jr.
Council Member Mathieu Eugene, Member of the Committee on Health
Council Member Vanessa Gibson
Council Member Rory I. Lancman
Council Member Mark Levine, Chair of the Committee on Health
Council Member Carlos Menchaca, Chair of the Committee on Immigration
Council Member Francisco Moya
Council Member Keith Powers, Member of the Committee on Health
Council Member Carlina Rivera, Chair of Committee on Hospitals
Council Member Ydanis Rodriguez
Council Member Deborah Rose
Comptroller Scott Stringer
Bronx Borough President Ruben Diaz
Brooklyn Borough President Eric Adams
Manhattan Borough President Gale Brewer
Queens Borough President Melinda Katz
Public Advocate Letitia James

CC: Deputy Mayor for Health and Human Services Herminia Palacio Commissioner Nisha Agarwal, Mayor's Office of Immigrant Affairs
Louis Cholden-Brown, Deputy Chief of Staff for Legislation, Planning & Budget, New York City Council

March 15, 2018

Open letter re: Urgent need to restore and increase funding for New York's TB response

Dear Mayor de Blasio, City Council Speaker and Members, Borough Presidents, Comptroller, and Public Advocate,

As your constituents, we write to thank you for this administration's preservation of funding for New York's response to tuberculosis (TB), and to appeal urgently for your support for increased resources to combat this growing infectious public health threat.

When it comes to TB, New York City is a leader—in the best and worst ways. The New York City TB program leads the rest of the country in adopting cutting-edge, cost-effective ways to prevent, detect, and treat TB. But the City has the third highest TB case rate of all U.S. reporting areas, according to 2016 CDC data. Preliminary 2017 trend data indicate not only an increase in TB incidence, but a rise in drug-resistant TB, which is even more difficult and costly to diagnose and treat.

Such figures are unfortunately unsurprising when one considers the paucity of resources committed to the TB response in New York City. Prior to this administration's tenure, a history of budget cuts to the New York City Department of Health and Mental Hygiene (DOHMH) Bureau of TB Control (BTBC) more than halved the City's contribution to TB control, from $16.43M in 2007 (adjusted for inflation) to just $8.59 million last year.

Because of similar cuts at the state and federal level, the BTBC's total funding has been reduced by half in the last ten years. And because of increasing case rates, funding per case of TB has decreased by over 56%. As a result, clinics have been shuttered, those that are open are in disrepair, and critical positions remain unstaffed. The immigrant communities that many of us represent are disproportionately affected.

Similarly short-sighted budget reductions in the late 1980s dismantled the public health response to TB, contributing to a massive outbreak of drug-resistant TB in New York City that cost over $1 billion to control. Let's not repeat history.

We ask you to ensure that the TB response is adequately funded and critical services restored by increasing New York City funding to the DOHMH BTBC in this year's budget to $14.89 million (a $6.3 million dollar increase over last year). We appreciate that—while ultimately the obligation of the locality—addressing TB is a shared responsibility, and we are making similar (but proportionally higher) requests at the state and federal levels.

We look forward to your leadership in ensuring an appropriate budget for a robust TB response in New York City. Please direct any questions and your response to Safiqa Khimani at Safiqa.Khimani@treatmentactiongroup.org.

Organizational endorsements
Academy of Medical & Public Health Services, Brooklyn, NY
African Services Committee, New York, NY
Apicha Community Health Center, New York, NY
Boom! Health, Bronx, NY
Callen-Lorde Community Health Center, New York, NY
Care for the Homeless, New York
End AIDS Now, New York, NY
(continued)

Exponents Inc., New York
Federation of Protestant Welfare Agencies, New York, NY
GMHC, New York, NY
Housing Works, New York
Latino Commission on AIDS, New York
Legal Action Center, New York City, State, and U.S.
Mexican Coalition, Bronx, NY
National TB Controllers Association, U.S.
NewYork-Presbyterian Lower Manhattan Hospital, New York, NY
The New York Immigration Coalition, New York
Treatment Action Group, New York, NY
Unity Fellowship of Christ Church NYC, Harlem, NY

Individual endorsements *institutions noted for affiliation purposes only*

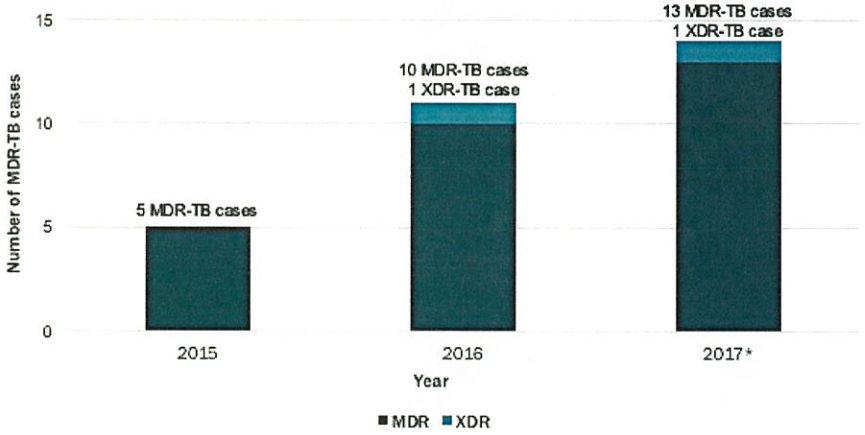
Maha Attieh, Arab American Family Support Center, Brooklyn, NY
Nicole Blonder, Health Coach, Brooklyn, NY
Joy Episalla, Treatment Action Group, New York, NY
Joel D. Ernst, MD, New York University School of Medicine, Bellevue Hospital Center, New York, NY
Mike Frick, Treatment Action Group, Brooklyn NY
Gerald Friedland, Professor of Medicine, Epidemiology and Public Health, Yale School of Medicine, New Haven, CT
Annette Gaudino, Treatment Action Group – HCV advocate, Bronx, NY
Jill F. Greenberg, MPH, Health Advocate, New York, NY
Mark Harrington, Treatment Action Group, New York, NY
Yael Hirsch-Moverman, ICAP, Mailman School of Public Health at Columbia University, New York, NY
Tiffany Hsu, Health Advocate, New York, NY
Safiqa Khimani, Treatment Action Group, Brooklyn, NY
Eunhye Kim, Korean Community Services, New York, NY
Erica Lessem, Treatment Action Group, Brooklyn, NY
Timothy Lunceford-Stevens, Healthcare advocate, New York, NY
Suraj Madoori, Treatment Action Group, New York, NY
Luis Mares, Latino Commission on AIDS, Astoria, Queens, NY
Barun Mathema, TB researcher, New York, NY
Lindsay McKenna, Treatment Action Group, Brooklyn, NY
Robert Monteleone, AIDS activist, New York, NY
Laura Moya, HIV tester and counselor, Iris House, New York, NY
Ann E. Rubin, Rise & Resist, Brooklyn, NY
Marco Salerno, Columbia University, New York, NY
Eric Sawyer, Cofounder of Act up New York and Housing Works, New York, NY
Sangey Tashi, Tibetan Community Health Network, New York, NY
Donna Hope Wegener, National Tuberculosis Controllers Association (NTCA)

Tuberculosis in New York City: A Growing Threat

Tuberculosis (TB) is the leading infectious killer worldwide, and New York City is not immune. TB is an airborne, communicable disease—if we don't prevent and treat it properly today, TB will spread, taking many more lives and costing much more to treat.

The New York City TB program leads the rest of the country in its cutting-edge, cost-effective programming to prevent, detect, and treat TB. However, New York has the 3rd highest TB case rate in the country, according to the U.S. Centers for Disease Control and Prevention (CDC). **TB is on the rise in New York City, as is multidrug-resistant TB** (MDR-TB), which is even costlier and more difficult to treat. The CDC estimates that a single case of MDR-TB in the U.S. averages costs of $294,000 in direct costs and productivity losses, and even more resistant cases known as extensively drug-resistant TB (XDR-TB) average $694,000. These costs are likely even higher in New York City. The financial and human toll of TB on New York is immense.

Since 2015, Multidrug-Resistant TB is on the Rise



Immigrant communities disproportionately bear the burden of TB in New York City. Among New Yorkers with TB, 85% are foreign-born, from over 67 different countries. The majority of New Yorkers with TB have been in the U.S. for five years or more, meaning they are likely entering the country with TB infection but not yet active disease, and there is ample time to intervene and prevent active TB disease from developing if resources are available to do so. Proactively addressing TB in linguistically and culturally appropriate ways is essential.

Funding crisis

The capacity for a robust TB response has been weakened over the years through eroding funding for TB from the city, state, and federal funding levels. The impact of these cuts has been grave, especially at a time when cases of TB and MDR-TB are

List of Chest Centers

Full-time *(losing Saturday hours):*

- Fort Green
- Corona

Part-time:

- Morrisania
- Washington Heights

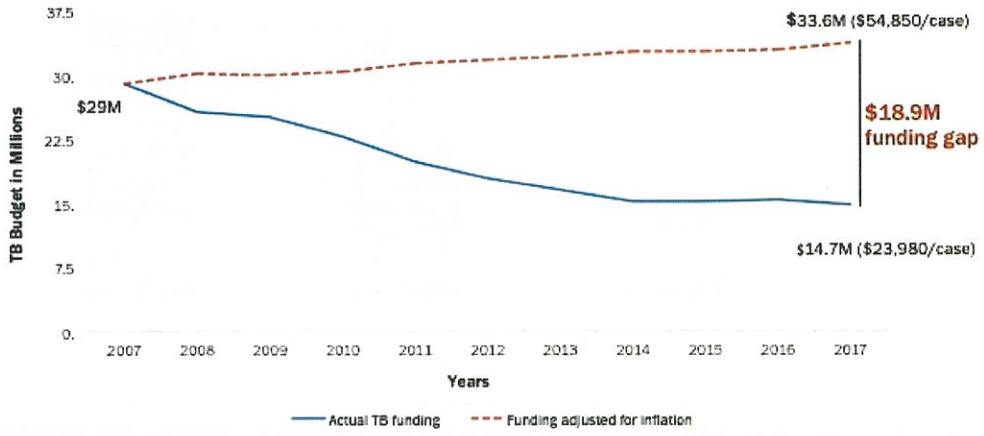
Closed:

- Brownsville
- Bushwick
- Jamaica
- Bedford
- Chelsea
- Richmond

on the rise, and as new treatment and prevention options offer great hope but require more resources. Many TB clinics have been closed. The remaining TB clinics are in disrepair, and have either been reduced to part-time, or are having to cut their convenient, patient- and community-friendly hours. The TB response workforce has been cut nearly in half, with key positions unfilled, limiting capacity for culturally-sensitive outreach. Funding available per case has shrunk from $54,850 in 2007 (after adjusting for inflation) to just $23,980 per case.

With these persistent cuts, New York City is repeating history. Similarly short-sighted underfunding of the public health response to TB in the 1980s contributed to a massive outbreak of drug-resistant TB in the early 1990s. Undoing that damage that took over $1 billion and years of work. By investing more in the TB response now, we can save orders of magnitude more work and resources, and avoid further suffering from TB.

New York City Department of Health and Mental Hygiene
TB Funding and Funding Adjusted for Inflation, 2007-2017



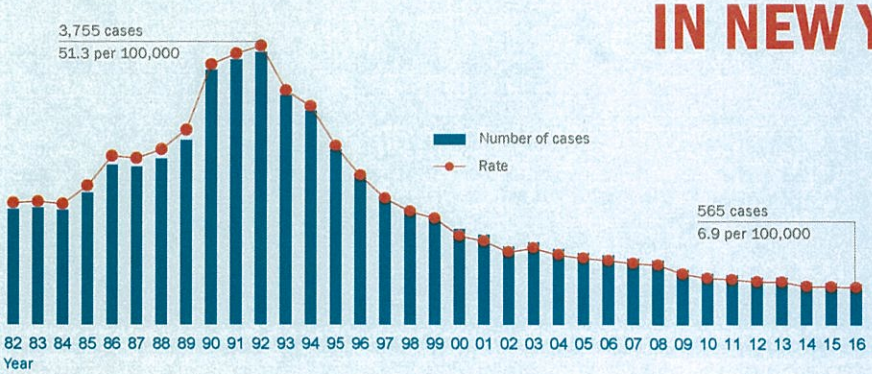
Inflation adjustment reflects the Consumer Price Index (CPI), https://www.bls.gov/cpi/tables/historical-cpi-u-201711.pdf

To do its part in closing this perilous funding gap, **we request an increase to New York City funding to $14.89 million to the New York City Department of Health and Mental Hygiene (DOHMH) Bureau of Tuberculosis Control (BTBC)**. This represents a $6.3 million increase over last year. We are making similar requests (though proportionally higher) at the state and federal levels. Restored funding would allow for reversing the increase in TB cases and accelerating the decline of TB in New York City through:

- Reinstating key staff positions;
- Hiring additional staff to conduct culturally-sensitive outreach and care;
- Restoring part-time clinics to full-time, and allowing for patient-friendly clinic hours;
- Collaborating with community providers to test and treat for TB infection and active disease for all high-risk New Yorkers.

TUBERCULOSIS

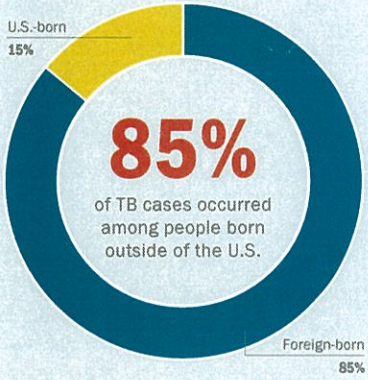
IN NEW YORK CITY, 2016



565 Number of tuberculosis (TB) cases verified in NYC in 2016

6.9 NYC citywide TB rate in 2016 per 100,000 people

COUNTRY OF BIRTH



MOST COMMON COUNTRIES OF BIRTH AMONG PATIENTS:

- China **124**
- United States (U.S.) **85**
- Mexico **34**
- Philippines **30**
- Bangladesh **26**
- Dominican Republic **22**
- Haiti **22**
- Ecuador **21**
- India **21**
- Guyana **15**

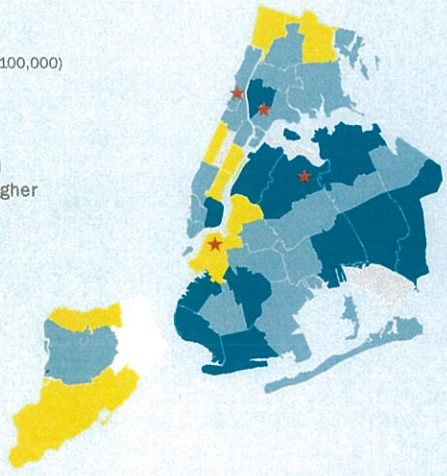
64% Proportion of foreign-born patients residing in the U.S. for more than five years at time of TB diagnosis

67 Countries of birth represented among patients with TB disease

TB IN NYC NEIGHBORHOODS

- Above citywide TB rate (7.0 to 20.2 per 100,000)
- At or below citywide TB rate (2.9 to 6.9 per 100,000)
- At or below provisional national TB rate (0.9 to 2.9 per 100,000)
- No NYC TB cases
- ★ Health Department Chest Center location

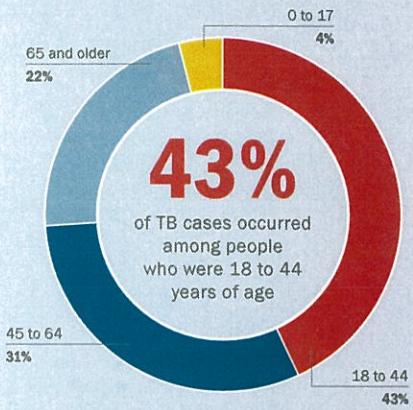
12 Number of United Hospital Fund neighborhoods with a TB rate higher than the 2016 citywide TB rate

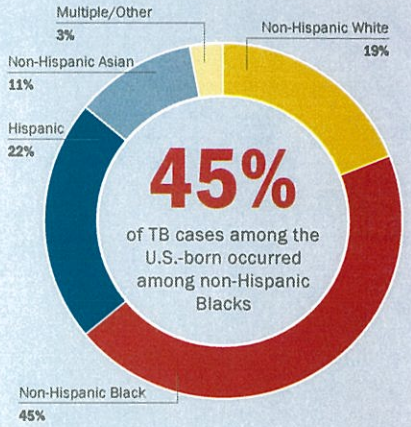


The Health Department provides TB services free of charge to ALL PATIENTS, regardless of their immigration status, insurance status or ability to pay

DEMOGRAPHIC CHARACTERISTICS

61% of TB cases occurred among males





CLINICAL CHARACTERISTICS

79% Proportion of TB cases with a pulmonary disease site

5% Proportion of TB cases among patients known to be HIV-infected

11 Number of TB cases identified in 2016 with a multidrug-resistant strain

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

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

☐ in favor ☐ in opposition

Date: 3/15/18

(PLEASE PRINT)

Name: Andrea Bowen

Address: 147 S oxford St Apt 1D Brooklyn 11217

I represent: Transgender & Gender Nonconforming Solutions Coalition

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

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

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Jerry WESLey

Address: 237 38th Street Brooklyn, NY

I represent: SATISFACTology Business Systems

Address: 1 World Trade CENTER 85th FL

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

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

☐ in favor ☐ in opposition

Date: 3/15/18

(PLEASE PRINT)

Name: Dr. Patricia Yang

Address: _____

I represent: NYC Health + Hospitals

Address: _____

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THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

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☐ in favor ☐ in opposition

Date: MAR 15

(PLEASE PRINT)

Name: Kevin Collins

Address: 50 Bway

I represent: Doctors Council

Address: _____

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Appearance Card

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☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Claudia Calhoun

Address: 131 West 33rd St NY NY 10033

I represent: New York Immigrant Coalition

Address: _____

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THE CITY OF NEW YORK

Appearance Card

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☐ in favor ☐ in opposition

Date: 3/15/18

(PLEASE PRINT)

Name: Erica Lessem

Address: 286 St Johns Pl, Brooklyn NY 11238

I represent: IAG

Address: 90 BROAD ST, STE 2303, NYC, NY 10004

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THE CITY OF NEW YORK

Appearance Card

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☐ in favor ☐ in opposition

Date: 3/15/18

(PLEASE PRINT)

Name: Dr. Mitchell Katz

Address: _____

I represent: NYC Health + Hospitals

Address: _____

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Appearance Card

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☐ in favor ☐ in opposition

Date: 3/15/18

(PLEASE PRINT)

Name: PV Ananthram

Address: _____

I represent: NYC Health + Hospitals

Address: _____

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THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

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

☐ in favor ☐ in opposition

Date: 3/15/18

(PLEASE PRINT)

Name: Matthew Siegler

Address: _____

I represent: NYC Health + Hospitals

Address: _____

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THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

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

☐ in favor ☐ in opposition

Date: 3/15/18

(PLEASE PRINT)

Name: Ralph Palladino

Address: 125 Barclay Street NY NY 10007

I represent: 2nd Vice-President, L.1549, DC37

Address: _____

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