CITY COUNCIL
CITY OF NEW YORK

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TRANSCRIPT OF THE MINUTES

Of the

COMMITTEE ON HOSPITALS

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MARCH 15, 2018
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HELD AT: COMMITTEE ROOM-CITY HALL

B E F O R E: COUNCIL MEMBER CARLINA RIVERA

COUNCIL MEMBERS: CARLINA RIVERA
MATHIEU EUGENE
ALAN N. MAISEL
FRANCISCO P. MOYA
ANTONIO REYNOSO

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

2 This is a microphone check. Today's date
3 is March 15, 2018. Preliminary budget hearing on
4 hospitals. Being recorded by John Biando.
5 COUNCIL MEMBER RIVERA: Thank you all for
6 being here. Good afternoon. For the preliminary
7 budget hearing. Good afternoon. I'm council member
8 Carlina Rivera, Chair of the City Council's Committee
9 on Hospitals and during today's hearing we will
10 review New York Health and Hospitals $7.4 billion
11 fiscal 2019 operating budget as well as new expense
12 funding for correctional health services and
13 performance indicators from the fiscal 2018
14 preliminary mayor's management report. Although the
15 City Council is conducting budget hearings on the
16 fiscal 2019 preliminary budget, today's hearing will
17 address H&H's budget as of the fiscal 2018 executive
18 budget. The Council made multiple requests to the
19 New York City Office of Management and Budget for an
20 updated plan but the agency would only provide a
21 budget that is nearly a year out of date. This
22 failure to share basic information undermines the
23 Council's ability to execute its charter mandated
24 role. The City Charter grants the City Council the
25 responsibility for oversight and investigation of the

2 property, affairs, and government of the City. As
3 the City's public hospital system, H&H constitutes an
4 integral component of the City's government and the
5 general welfare of its residents. In order to
6 analyze H&H's fiscal health and to ensure
7 transparency and accountability in our municipal
8 hospital system, the Council requires complete,
9 accurate, and timely financial information,
10 particularly given the City's substantial investments
11 in H&H which will exceed $1 billion dollars this
12 fiscal year. I look forward to receiving H&H's
13 fiscal 2019 executive budget well in advance of the
14 committee's fiscal 2019 executive budget hearing.
15 Specifically, I look forward to reviewing the fiscal
16 implications of the seven actions you outlined during
17 last month's oversight hearing on H&H's
18 transformation plan, One New York Healthcare for our
19 Neighborhoods. I'm particularly interested in
20 reviewing your plans to generate revenue through
21 improved billing and hiring practices and to reduce
22 expenses through targeted personnel restructuring
23 ensuring the financial health of our municipal
24 hospital system proves vital to achieving our shared
25 vision of a healthy and equitable city. We know that

2 Safety Net Hospitals serve a crucial role in caring
3 for our city’s most vulnerable and marginalized
4 citizens including undocumented immigrants, low-
5 income children, and people with mental illness and
6 substance abuse issues. Recent actions by Congress,
7 including the extension of funding for the Children’s
8 Health Insurance Program and the delay of any cuts to
9 the disproportionate share hospital payments have
10 provided some near fiscal relief for the Safety Net
11 Hospitals including H&H. However, other critical
12 aspects of our countries healthcare system including
13 the Affordable Care Act, Medicaid, and Medicare,
14 remain at risk and we know significant work remains
15 to mitigate the billion dollar deficits facing H&H.
16 We have a unique opportunity to capitalize on this
17 period of transition in our countries healthcare
18 system. As you know, health professionals are
19 increasingly providing care outside of traditional
20 inpatient facilities with urgent care sites and
21 health technology serving patients in new ways. H&H
22 must adapt to this landscape while also strengthening
23 the healthcare facilities that serve as the bedrocks
24 of their communities. H&H’s $3 billion dollar
25 capital plan will prove vital in these efforts from

2 implementing a state of the art electronic medical
3 record system to purchasing essential medical
4 equipment and renovating old buildings and
5 structures. I would like to thank my committee
6 staff, Finance Analyst, Jeannette Merrill, Policy
7 Analyst, Crystal Pond, and Committee Council Zae
8 Emanuel. You will now be sworn in.
9 Do you affirm to tell the truth, the
10 whole truth, and nothing but the truth in your
11 testimony before this committee and to respond
12 honestly to Council Member questions? Thank you.
13 DR. KATZ: Okay, very good. Members of
14 the Committee, I'm so happy to be here. I'm Dr.
15 Mitch Katz. I'm the President and Chief Executive
16 Officer of New York City Health and Hospitals. I
17 really appreciated the dialogue that we had two weeks
18 ago. I feel incredibly supported by the council, the
19 other parts of the New York City family to really
20 make health and hospitals realize all of it's
21 potential. It's an amazing organization. I'm so
22 pleased when I go around to the different hospitals
23 and clinics and meet the doctors and nurses and other
24 professionals caring for people. It's an amazing set
25 of people who are working under extremely difficult

2 conditions but with the focus of taking excellent
3 care of our patients and I'm absolutely committed to
4 making the system at H&H as good as the people in it.
5 Part of that is to make us fiscally solvent. I have
6 never actually run an organization but maintained the
7 deficit. I have started with organizations with
8 deficits. It is very unhealthy for an organization
9 to not have a clear path to fiscal solvency. We all
10 have to agree on what the subsidy that H&H will need
11 in order to care for its uninsured patients but that
12 has to be predictable and reasonable and it can't be
13 middle of the year we need extra dollars. That's not
14 sensible. That's not how I plan on going forward.
15 I've only been here just a little under three months.
16 I feel like I have a much better sense now than I did
17 two months ago and I feel absolutely certain that
18 together we can make this happen. For this year, and
19 I very much take Chairperson's comment that ideally I
20 would be here with the three year forecast and all of
21 the information and I have made it clear to all that
22 that is the appropriate expectation and we will get
23 there. I'm happy to say, that at least for this
24 year, we have met the target of $1.2 billion that
25 through reducing costs by $387 million and increasing

2 revenue by $820, we have met it, we will meet it.
3 The major issues are going forward, the out years.
4 To this year's decreased costs were by improving
5 supply chain, using attrition, a major elimination of
6 consultants, and just last Friday, we decreased
7 administrative staff at central office only, not at
8 the facilities, not the hospitals or clinics, by 35
9 positions for an annualized savings of $5 million
10 dollars. On the revenue side, we're improving
11 billing, we're increasing revenue from our health
12 plan, we're expanding value based payments,
13 increasing district funding, enhancing our care
14 restructuring program, there's an increase to
15 federally qualified health centers and of course, and
16 I'm very grateful to the council and to all the
17 others who worked to help push off the two year
18 dish(?) cut. That would have been disastrous at this
19 point. I will talk later, although the ultimate cut
20 still happens, and actually would be even more
21 dramatic, I'm grateful because I feel together this
22 gives us a ramp, right? This gives us the time.
23 Part of the challenge on the seven point plan that
24 you referred to Chairperson is that it's not
25 something I can do by memo, not something that is as

2 simple as say okay now we're going to build. It
3 requires everything from when the person comes in to
4 the clinic or hospital. Are they appropriately
5 registered? Do we have their insurance information?
6 Do we call for prior authorizations for their
7 services? When they're seen, do we code for those
8 services appropriately? Do we send the bill? Do we
9 send the bill to the right place? When the bill is
10 sent is the correct code on that bill so even if you
11 coded it correctly, if the code is not on the bill,
12 you won't get paid? After you've sent the correct
13 bill, sometimes insurance companies, being insurance
14 companies, still don't pay. You have to appeal.
15 Several of them simply deny paying and that's
16 unacceptable if the contract says but you have to
17 appeal. So each of those steps requires work at H&H
18 but if we follow through on all of those steps, you
19 will find that H&H will not have to shrink. H&H will
20 be able to grow. H&H will be able to improve
21 staffing at all our facilities. So, just for review,
22 we're going to reduce administrative expenses. We're
23 going to bill people with insurance. We're going to
24 code appropriately. We're going to stop sending
25 paying patients away. We're going to hire the

2 positions that are necessary to generate revenue.
3 We're going to start providing those services that
4 are well reimbursed and very importantly, we're going
5 to convert the uninsured to people who have insurance
6 and I think we spoke a little bit about this. The
7 City has had successful efforts to enroll people into
8 Medicaid. The real opportunity is people who are
9 just above the Medicaid line. Remember that Medicaid
10 is available if you're up to 139% of poverty but many
11 still, being at 200% poverty, is still to be very low
12 income in New York City. People at that level
13 struggle. They come to us. We need to get those
14 people onto the basic health plan or get them
15 insurance from the exchange to the extent that we
16 simply keep providing them sliding scale services,
17 we're undermining the ACA. We're not bringing in the
18 literally hundreds of millions of dollars that are
19 available to H&H and we're part of them not getting
20 all the benefits that they can get. When they get
21 the exchange it's not just that it's the same $10.00
22 copay but it's all the other benefits that they are
23 going to get by virtue of being insured. So I think
24 that is a huge opportunity for the City and the good
25 thing is we know who those people are. They're

2 already coming to us. So it's simply a matter of
3 having the right people available so that we are able
4 to make those connections. Equally important is
5 expanding our primary care footprints even within our
6 own health plan, our fully owned health plan, the
7 majority of patients are assigned to a primary care
8 doctor outside of H&H. Why is that? Is that because
9 that's what the people are requesting? No. It's
10 because we don't have appointments available. We
11 don't have appointments available then appropriately
12 they're sent to other providers. The patient's care
13 should always come first but often they're requesting
14 one of our sites and we are full. So, I have a new
15 very energetic, Dr. Long, head of primary care. He
16 knows he needs to hire 55 new providers. We are
17 doing everything possible to hire those providers and
18 we're going to have more creative models of using
19 pharmacists, using registered nurses, so that we are
20 providing a really great service. On the physical
21 front, we are opening a new $28 million dollar
22 community health center on Staten Island as soon as
23 we receive New York State Department of Health
24 approval, we will be opening this spring. I'm very
25 pleased about that. I was so happy to be with the

2 Chairperson at the gouvenir(?) to open up those
3 beautiful beds. I know those were long in coming to
4 the city but I think that is a really important area.
5 I know the chair and council member Margaret Chin
6 worked really hard to make that happen and I
7 appreciated that you were at the opening event. We
8 will continue to improve care throughout H&H using
9 the One City Health we'll continue to expand our
10 population healthcare so that people both in our
11 facilities and beyond our facilities are getting the
12 care that you would want for your family, that I want
13 for my family to be delivered by H&H. We are trying
14 to be able to provide great care at all levels. Last
15 year universal depression screening for adults in
16 primary care practice became standard practice at
17 H&H. We're screening all pregnant women and new
18 mothers for maternal depression and linking them to
19 care. We have behavioral health services at all of
20 our five family justice centers which provide a
21 comprehensive range of services to survivors of
22 domestic violence. I know this council has done some
23 amazing work around opioid addiction and trying to
24 make New Yorker's have the appropriate services, they
25 don't lose their lives from this awful epidemic. We

2 have miloxone(?) kits available to the community for
3 free at New York City H&H Lincoln and we're going to
4 expand this to all our hospitals. I'm very pleased
5 to hear that within our family center at Riker's,
6 family members are actually taught that when someone
7 leaves Riker's they're at incredible risk for
8 overdose because they may have once used and they
9 didn't use while they were in jail, now if they go
10 back to using at a dose similar to what they were
11 using before jail, that's a time when they're at
12 terrible risk for overdose and so we actually counsel
13 the families, we give them Narcan. I think that it's
14 an important part of the solution. We also know that
15 one of the solutions is to be able to have providers
16 who are able to prescribe Buprenorphine. We have
17 increased the number of providers to 450 through our
18 efforts, the number of patients who receive medicated
19 assistive treatment will increase to 2,500 over the
20 next three years. Our goal is ultimately more than
21 5,000 New Yorker's gain access to medical assistive
22 treatment. I want to mention a few highlights around
23 capital projects thanks to this great council,
24 Council Member Debbie Rose, a thank you for her
25 contribution to our community health center on Staten

2 Island. Council Member Eugene for his ongoing
3 contributions to Kings County. We are renovating and
4 expanding the adult emergency room at Elmhurst and
5 we're appreciative to the Queens borough President,
6 the Queens City Delegation for their support for an
7 issue that I know is close to your heart. Chairperson
8 Roberto Clemente clinic in Manhattan is getting a new
9 renovation which I know you have worked on and I
10 appreciate as well as the work of former Council
11 Member Rosie Mendez and the Manhattan borough
12 President for their support. Having the appropriate
13 equipment helps us a great deal and I know various
14 members of the council have provided that for
15 hospitals in their area. We are hard at work at a
16 new hospital tower in Coney Island which flooded in
17 Hurricane Sandy. We're working on our epic rebuild
18 so that all of our facilities have the appropriate
19 computer technology. I'm going to close by just
20 mentioning correctional health. I want to say how
21 happy I was even from California when I heard that
22 New York City H&H was taking over correctional health
23 because as a public hospital person I believe
24 strongly that this is work that should exist in the
25 public sector, that public hospital doctors are the

right people to care for people who are in jail, who are leaving jail, to arrange the kind of aftercare that's necessary and now that I'm here, of course, I'm even happier that you made that decision a couple of years ago and made it happen. I'm fully committed to our correctional health program. Over the last two years, we have operationalized the 24 hour seven day a week pre-arraignment screening unit in the Manhattan Detention Center. We've nearly tripled the number of patient's receiving Hep C treatment. We've opened seven satellite clinics to bring the services closer to our patients. We've opened two new specialized housing units. We've tripled the number of daily patients on methadone maintenance and buprenorphine. We'll conduct a Queens pilot to streamline the conduct of court ordered forensic psychiatric evaluations. We're working on enhancing mental health services for women in jail. I was very pleased to hear that 16 and 17 year olds will not be at Riker's. I think that is the right decision. 16 and 17 year olds in my opinion do not belong in a place like Riker's. I'm absolutely committed to H&H taking on that service. I think that one of the examples of tremendous synergy is that primary care,

2 in and of itself, can reduce recidivism back to jail
3 because primary care doctors, part of our work is
4 always connecting people to existing services. So
5 when we see somebody, we're not just interested in
6 their hypertension or their diabetes, we're
7 interested in where are they living, how are they
8 getting food, are they getting the benefits that
9 they're entitled too? And so part of why I think
10 this is such an important thing for correctional
11 health to be in the public sector is because it makes
12 it so much easier to make those connections. With
13 that, I'm here with my Director of Managed Care, my
14 CFO, and our Head of Correctional Health and other
15 staff members as well. We appreciate your support.
16 We appreciate your questions. We appreciate your
17 thoughts on how we transform this into a really
18 successful, terrific system that people are proud to
19 work in and get their care at. Thank you.
20 COUNCIL MEMBER RIVERA: Thank you and of
21 course I want to acknowledge Council Members Alan
22 Maisel, Dr. Mathieu Eugene, and Antonio Reynoso,
23 thank you for being here. So thank you Dr. Katz for
24 your testimony. You know we're both on a similar
25 timeline for a new position and I want to thank you

2 for being here. I guess two hearings in just a few
3 weeks. So we're experiencing this together. You
4 know, in this position, my constituents and the
5 people of the City of New York they require
6 transparency and accountability and we expect the
7 same thing from our municipal hospital system. So,
8 we want to make sure that the council is receiving
9 complete, accurate, and timely financial information
10 and I know I said this in my opening statement but I
11 really wanted to underline this because we have had
12 some challenges in the past in really requesting and
13 for your agency to deliver accurate and comprehensive
14 reporting. So we hope that under your new leadership
15 we're going to have a better relationship in terms of
16 communication and exchange of information. So, I
17 guess you've pretty much laid out the plan, the seven
18 point plan more or less. I want to ask whether you
19 would commit to in the future putting a dollar amount
20 to each of those so whether it's administrative
21 expenses, billing, coding, hiring, the reimbursement
22 of services that bring more money in and increasing
23 enrollment, really putting a monetary value on that
24 so we can see in terms of your financial projections
25 where H&H is going to be?

2 DR. KATZ: Absolutely. I think the only
3 thing I'll ask your indulgence is a few of them run
4 together. So for example, how much money you get
5 from your insurance billing depends on how successful
6 you are getting people insurance and how good you are
7 at coding. So, I will probably lump a few, part of
8 why I've separated them and not just said we're going
9 to increase insurance is that I'm aware that prior
10 efforts sometimes have not worked and so I don't want
11 to be in a position of suggesting to people that I
12 think it's just as easy as oh I think we're going to
13 bring in a lot more privately insured people. So,
14 I've tried to separate it so people can understand
15 both why it takes some effort to do this but the
16 decrease in administrative expenses, that's clearly
17 separate. So that one's easy to separate out. I
18 think the other, I may wind up with one figure that
19 somewhat encompasses them because again they're not
20 exactly separable. Coding is not if nobody is
21 insured or fewer people are insured, coding doesn't
22 help you. Conversely, if you send a lot of bills but
23 they're not appropriately coded, you don't get any
24 money. So if that's an acceptable friendly amendment
25 I absolutely believe that the council should see all

2 of the figures. There's certainly, and again, I want
3 to apologize, this is not, I'm still learning New
4 York City and I'm still learning how things are done
5 here. There's no information that I have that I
6 wouldn't at this moment share with you. Obviously,
7 we were just at our own finance committee meeting
8 yesterday with the Board, all of the transparency is
9 actually good on where we are now where I think we're
10 all sort of trying to figure out is okay, but you
11 don't run a system based on where you are now. You
12 run a system based on where are you over the next at
13 least three years. I think of a standard. If you
14 start getting more than three years it does get very
15 hard to project out since so much depends on
16 political. So the place where we're not where I would
17 like to be is I would like to be with you in saying
18 okay so I've solved this year, or we've solved this
19 year but here's where we are at the end of next year,
20 the end of the year after, and the end of the year
21 after and I am in no means holding that information
22 from you. I don't have that information at the
23 moment. I'm absolutely committed to working with the
24 council, working with my staff, working with OMB and
25

2 the mayor's office and being able to bring you
3 projections that are meaningful.
4 CHAIRPERSON RIVERA: So you can confirm
5 that this plan, the One New York Plan, is going to
6 change and with everything that you're considering
7 all the factors, the projections, the political
8 climate, etc., this plan will change and for example,
9 you mentioned a big amount earlier. So there's a
10 $483 million dollars in projected revenue from
11 Medicare waivers. That's one of several aspects of
12 the plan and that proves unrealistic in this climate,
13 correct? So when do you think the council can expect
14 an updated plan considering that certain things are
15 intertwined and dependent on the other and including
16 revenue, savings, from all the new initiatives that
17 you mentioned?
18 DR. KATZ: Right. I'm thinking two
19 months, two to three months.
20 CHAIRPERSON RIVERA: So for the May
21 hearing? Just want to have something to look forward
22 too. Okay great. So, in addition to the Medicaid
23 waivers, so what other parts of the plan require
24 revision? For example, fiscal 2019 projections
25 include $369 million in revenue from federal and

state charity care and $285 million revenue from health insurance initiatives. Are these numbers still accurate?

DR. KATZ: Introduce yourself.

MR. ANTON: Hi, I'm Vivian Anton, CFO for H&H. The $369 million dollars that you note here are through waivers that would we expected to get from the federal government. We clearly are not in the position to attain that today so we will be retooling against the seven point plan that Dr. Katz just mentioned. The only other piece that is not appropriate in this plan is the increase of headcount reductions that move from $150 million dollars to $448. I think Dr. Katz has already said that that, we are at a place today where we should be looking to add more clinical staff and so we would have to retool on that. However, administrative expenditures are still a big part of our reduction plan.

DR. KATZ: Right, I think this best relates, you know there are two narratives that are possible, there's the shrink out of the budget problem and there's the grow out of the budget problem and part of why I don't personally think that the shrink is likely to be as effective as you, there

2 are two problematic parts of shrink; one is as you
3 lose staff, you lose revenue. So especially one of
4 the challenges of attrition is you don't necessarily
5 shrink equally. So you could actually be in a
6 position where you lose certain members of the care
7 team and can no longer provide the service,
8 therefore, you no longer get the revenue but you
9 still have some members of the care team and so you
10 have the expense, now you have none of the revenue,
11 now you're worse off than you were before. So I
12 think that's one part of why shrinking does not work
13 very well always. The second reason is I think there
14 is a huge amount of potential at H&H and that we
15 would do better rather than saying to people there
16 are going to be fewer and fewer staff which then puts
17 at risk safety and reputation, saying let's grow the
18 things we're really good at. It may not be growing
19 everything and I think people understand that that's
20 true whether you're H&H or you're PresB, or any other
21 group. No one, in general, you can't succeed in
22 every market in every service but there are a lot of
23 things H&H does super well and we should do more of
24 those things. That may mean that people have to do
25 different jobs. That we need people to move from one

2 thing to another but I don't think that shrinking is
3 going to be the most successful method of getting us
4 out of our current problem and that's why I've asked
5 that we revise looking at that number and instead
6 focus on where are the areas where additional staff
7 actually bring revenue in excess of their costs.
8 That's what you want, you want to look at those areas
9 where if you hire people, for example, a productive
10 primary care doctor can often bring two to three
11 times the salary of a primary care doctor to your
12 overall system because it's the lives that come in
13 it's not the visit. It's the fact that then people
14 need additional tests, those tests get billed, the
15 people then need hospitalizations, so there is a path
16 here.
17 CHAIRPERSON RIVERA: I asked you about
18 utilization because of course that has a lot to do
19 with who's coming into that hospital. We talked a
20 lot in the last hearing about underinsured and
21 uninsured patients and making sure that we are
22 serving them. So in the first four months of fiscal
23 year 2018, H&H provided healthcare services to about
24 632,000 unique patients which is actually a 2%
25 decrease when compared to the same period of the

2 previous year. However, your report says that the
3 downward trend maybe flattening. So what data would
4 that inform H&H’s assertion that the downward trend
5 may be flattening and give the need to increase the
6 patient population in order to increase our revenue,
7 why doesn’t the report include targets for the number
8 of unique patients served and what are your goals?
9 And I’ll ask you about Metro Plus as well because I
10 know you had a million target for enrollment that I
11 believe you scaled back and I’ll ask you about that
12 as well.
13 DR. KATZ: So, right now, utilization is
14 decreasing, not because people don’t want our
15 services but because we’re full. We tell people, you
16 call, we say we don’t have an appointment because we
17 don’t. And I think that if we’re going to be able to
18 grow then we have to be able to have appointments for
19 people who need to come forward for services. I
20 think the part of, and I want to make sure that I get
21 it right, I fully support the use that occurred
22 around attrition, you had a major, H&H had a major
23 financial problem and a need in the least disruptive
24 way to decrease the size of its budget. The problem
25 is that you can only use attrition so far and then at

2 a certain point it ceases to be a useful broad
3 technique because now you're affecting your ability
4 to see new people and that is the point that I think
5 we've reached and so the strategic use of attrition
6 is, so one of my first things on attrition is stop
7 holding nurse positions when a nurse announces that
8 he or she is retiring. There's no savings in that.
9 What actually happens is that you have to use
10 registry or overtime or some other form and in fact,
11 all of those nurse positions did ultimately get
12 approved in the review process. So it wasn't that
13 anyone was ever saying no but if you, in
14 bureaucracies, if you set up a process, you create a
15 delay. So some nurse would announce that he or she
16 was leaving and then that unit would send a request
17 to the facility and the facility would review all of
18 their positions and they would agree the nurse was
19 needed and then they would send that position to
20 central office and then central office would review
21 it and they'd say that position is needed and then
22 you would get an agreement to hire. Well, that's all
23 great but now three months have gone by and meanwhile
24 the nurse is not there. I also discovered that
25 through a problem in communication we were holding

2 grant funded positions. Well that's not useful to
3 anyone. You get a grant, having no one in that
4 position does not save anybody any money. So I think
5 the place I want to be in is to acknowledge the value
6 that attrition played and now say we need a more
7 strategic, thoughtful point now because we achieved
8 the easy part of the attrition. Now, we'll only work
9 if used in a more strategic way.
10 CHAIRPERSON RIVERA: So you mentioned
11 some of the hospitals are full and you can't get an
12 appointment and at the last hearing you mentioned how
13 you're really looking into the scheduling system and
14 it does need an overhaul. It's not centralized and
15 in fact, the e-record implementation was an epic
16 failure. I know that you're moving this along.
17 You've cut the consultants, some of the people that
18 have really delayed this process in all honesty
19 because of inefficiency and incompetency but is every
20 hospital full? I mean, aren't there some hospitals
21 who do have appointments available who can serve
22 patients with the best quality care and what are you
23 doing to address each hospital individually?
24 DR. KATZ: Thanks. So the place where the
25 delay is either in the case of primary care or in the

2 case of specialty care and it exists in both the
3 hospitals and in our community clinics and federally
4 qualified health centers. We do have the ability for
5 hospital beds although there are exceptions so in a
6 very positive thing that happened two weeks ago, we
7 had two rehab units that were half full, one at
8 Queens, one at Elmhurst, Elmhurst has had a major
9 shortage of medical/surgical beds resulting in
10 backups to the emergency department with cooperation
11 of labor and the people involved, we moved the rehab
12 from Queens to Elmhurst so now we have one full unit
13 at Elmhurst and now we're negotiating with New York
14 State Department of Health to turn that rehab unit
15 into med/surgical beds. But in general that's an
16 exception. In general we are good on med/surgical
17 beds. It's the outpatient appointments. You're
18 absolutely right that the system is heterogeneous. If
19 somebody wanted an appointment at Renaissance, as a
20 new patient appointment in the next week or two,
21 that's entirely doable and I commend Renaissance who
22 just did a really positive redesign to shorten the
23 time it takes for a patient to be seen. They're to
24 be commended for that. If you wanted a primary care
25 appointment at Belleview where you were both born and

2 served as the community advisory board, you would
3 find that the wait is months. Now, there are things
4 that we can do to try and make sure that people
5 recognize well but Renaissance is providing great
6 care in a very nice center in an important part of
7 the city but some people have always gone to
8 Belleview. They want to go to Belleview. So in an
9 ideal world you try to move resources rather than
10 people. You try to let people choose and then move
11 the resources to that but of course, facilities,
12 space is an issue, support staff is an issue and so
13 it's never even and again I don't think that we've
14 done a good enough job on focusing on what is it that
15 the patients really need and how do we provide that.
16 I think it's been too much about the bureaucracy and
17 not enough about the actual patients and that's
18 something that people understand and that I don't
19 accept and that we can change.
20 CHAIRPERSON RIVERA: So I just want to
21 ask one question about Metro Plus and I know that my
22 colleague has a question. So I know you had goals to
23 enroll a million at some point and now you're looking
24 to achieve I think it's a 675,000 member goal
25 outlined in the transformation plan. So what I

2 wanted to ask was New York City is home to nearly one
3 million people who lack health insurance and there
4 are a lot of communities such as Bushwalk, Brooklyn
5 that presents uninsured rates of more than 22%. So
6 you stated that a large percentage of this uninsured
7 population is actually insurable and what informs
8 this assumption?
9 DR. KATZ: The information we have about
10 demographics and income level and taking an overall
11 assessment of the percent of low-income people in New
12 York City who are documented and would be able to
13 receive insurance. Also, part of what I've learned
14 about historic and this is not what we're doing
15 today, but this is historic, is if somebody just said
16 I just like to be in Options, I'm not interested in
17 applying, we'd just say fine. Which again is not the
18 right answer for the system or for that person. So
19 in a sense, of course it's that, I mean the system
20 was not created to say the way I would think we would
21 all want it. The great value of a sliding scale
22 system is we want it to be, ideally, I would say,
23 free or very, very low cost, sometimes people
24 appreciate paying $2.00 or $5.00 and making their
25 contribution but for people who are not eligible.

2 But if you have a system where it’s actually easier
3 to not apply for insurance, which is our current
4 system, then people don’t join. So that is very
5 much, I want to say changed. It is certainly
6 changing. I don’t think we yet have enough people at
7 all of the hospitals for engaging people who may have
8 been on the Options Program sliding scale who nobody
9 ever said I’ll help you. Let’s get you onto coverage
10 and again it’s not an immediate answer because
11 remember that unlike Medicaid, the exchange has an
12 open enrollment period. So the truth is if someone
13 comes today, they can’t actually help them to enroll
14 in the exchange. But we can for the first time in
15 H&H now say hey you’re on the sliding scale, you are
16 eligible for the exchange, we’re going to continue to
17 provide the sliding scale for you until the open
18 enrollment period of course but then once the open
19 enrollment period comes, we’ll be helping you to move
20 onto the exchange and not only will you not be paying
21 more, you’ll be paying less and we’re making sure
22 that in every case, helping people to be on the
23 exchange is they’re eligible will be a better deal
24 for them. For people who are not eligible for the
25 exchange, then of course, we should provide the most

2 generous sliding scale possible. So that's what
3 hasn't happened. The city's efforts again have been
4 focused in the community, which again is wonderful,
5 and I'm sure our numbers would be way worse without
6 that but here we're actually seeing the people and
7 they're coming to us. They're in front of us but
8 we've never said we want to help you to apply for
9 insurance. So it is a culture change.
10 CHAIRPERSON RIVERA: Yeah, like you need
11 people there to help people navigate the system and
12 fill out the paperwork which could be in itself could
13 be incredibly intimidating and then there's the
14 language access and the education disparities. You
15 mentioned in your testimony, creative use of
16 pharmacists and nurses and when we're thinking of all
17 the comprehensive services that you have to provide
18 to a constituent to make sure that they understand
19 their rights and what's available, I encourage you to
20 make sure that nurses do their job and doctors do
21 their job but that we're also utilizing the community
22 based organizations in the area that are helping
23 people navigate because there's already trust
24 established in those organizations. I want to let my
25

2 colleague ask his question since we did mention
3 Bushwalk. Council Member Reynoso.
4 COUNCIL MEMBER REYNOSO: Thank you. You
5 were doing a great job Chair. I would have sat here
6 all day listening to the questions that you were
7 asking. It is extremely insightful. This being a
8 new committee, I being a new member of this
9 committee, I'm learning a lot about local hospitals
10 in my district like Woodhull but also just the
11 uninsured rate situation in Bushwalk for it to be one
12 of the highest in the City of New York. I'm really
13 looking forward to being able to tackle that issue
14 with partners like the Chair and also in H&H. But
15 again, I'm grateful for the H&H committee. I wanted
16 to ask gentrification exists in many areas in
17 communities where your hospitals are, one is in
18 Bushwalk and Bedsty being one of those in Woodhull
19 for example. So I see a decline in year in and year
20 out in Woodhull Hospital for example in patient
21 visits which I wasn't aware of until this hearing.
22 Just want to speak to how do you attract populations
23 that probably went to private hospitals. So I think
24 you come back to a hospital like Woodhull and not go
25 to a private hospital, I just want to know, do you

2 even take that into consideration or are all
3 populations treated the same or are the strategies
4 are all the same because I'm concerned now just like
5 in my schools. My schools are under-enrolled by 50%
6 and 60% in some cases because these new families
7 coming into the district still haven't created, they
8 still have children but now we're starting to see an
9 increase in enrollment ten years later when those new
10 people moved and now are starting to have families,
11 we're starting to see enrollment go back up and we're
12 looking forward to that in our schools. Does that
13 apply in hospitals in any way that looking at the
14 demographics of a population, how they're shifting,
15 how they're changing and the physical space where our
16 hospital is in?
17 DR. KATZ: Sure. Well, first I have to
18 tell you touring Woodhull with you was like being
19 with a rock star. The number of people who came up
20 to you who recognized you, who knew you from the
21 neighborhood really did my heart good and it's one of
22 the things that's so much fun about being back in New
23 York City is New York City has always been a town of
24 neighborhoods and I love the intense ethnic mix, the
25 fact that Polish is one of the, who would have

2 thought that right, is one of the three languages of
3 Woodhull. It's the thing I most love about New York
4 City and it was, I really appreciated going with you.
5 I appreciated for everybody to know the council
6 members tweet about having his baby at Woodhull was
7 something which got a ton of response. The midwife
8 greeted him like he was a close member of her family.
9 It was very positive. I think that the hospitals of
10 H&H are very attractive places to get care. We have
11 academic affiliations. We have doctors and this is
12 very important to me, who are salaried. They don't
13 make money by sending people for unnecessary
14 procedures. They only have the focus of the patients
15 in mind and Woodhull is filled with really
16 thoughtful, terrific doctors. I think our challenge
17 in attracting people is that we have not put as much
18 effort into answering the telephones, having friendly
19 schedules, the sort of customer service. And people
20 make decisions sometimes. At the end of the day, you
21 want to see really great doctors and nurses and
22 pharmacists and social workers but I get it that if
23 you call and nobody answers the phone, you're like
24 what's going on here, I'm going somewhere different.
25 So I think if we solve, and we will, the customer

2 service, patient experience part, which will involve
3 some facilities, you and I were together. I have
4 seen many, many public hospitals in my life of all
5 sorts. ED, Woodhull, not enough space but that's not
6 a modern, you can't line up gurney, gurney, gurney,
7 gurney, that's my 1980's residency. That's not what
8 anybody considers modern healthcare. We have, thanks
9 to you a plan about fixing that but I think that we
10 can attract paying patients and we also always want
11 to be relevant to people who are uninsured and can't
12 pay. That's our core mission. I just feel we're
13 good enough. When I came here one of the things that
14 I wanted when I chose my benefits is I made sure I
15 chose a plan that I could go to H&H with because not
16 all the city plans can you use H&H. I chose one that
17 would enable me to take me and my family to H&H. I
18 want us all to use our own hospitals and I think that
19 in of itself will improve the quality when people see
20 someone like you, it makes them feel good. My
21 hospital is good enough that the council member chose
22 to come here and then it's also just another set of
23 eyes and ears. So you might say I got great service
24 but I noticed there was a woman who was waiting
25

several hours at radiology. So I think it's something we can do together.

COUNCIL MEMBER REYNOSO: So I'm glad to hear the customer service part. I agree 100%. I never name dropped when I went to Woodhull anytime. I never told them I was the council member, I just wanted to be a normal person walking into Woodhull so I don't get special treatment and in doing so I found, I waited two hours one time to go see a midwife. I waited three hours one day and another day I waited like 30 minutes. So it varied and I just wanted to see the experience. I wanted to talk to the finance person. I wanted to do everything and it worked because I got an eye-opening experience there and I want to be able to express that to you in a positive way. I want to use my experience as a way to make it better. So just to go through that tour. I'm glad you came. They were very excited that you were there as well. The whole team showed up. There were folks that I hadn't seen a long time in that tour. But I'm glad you saw the ED because I don't know what a good ED looks like all I know is Woodhull. So I asked you that, I asked on a scale of one through ten, where does Woodhull rank among

2 hospitals. I love Woodhull and I think it's amazing
3 and you were like well it's kind of in the middle.
4 Have you seen Harlem Hospital is what you told me. I
5 haven't seen it. I'm excited to take a tour one day
6 but I guess that's the next part, capital dollars.
7 We have a lot of opportunity in capital funding that
8 short-term investments into city sites like Woodhull
9 that we can really invest in that we could take
10 advantage of right now when the city's doing well,
11 when we have the revenue and I looked at your budget
12 and it's an increase in the capital budget but only
13 slightly, not an increase where these one shot deals,
14 this is going to happen, half a million dollars or
15 half a million dollars one time for this. It's not
16 something that's like a long-term contract of a
17 baseball player. It's a one shot deal. It's a one
18 year contract. Why not take advantage of that to
19 upgrade Woodhull right now to a place where it looks
20 like a Harlem Hospital? I'm just seeing the budget,
21 I don't see that being a part of it actually
22 upgrading the facilities.
23 DR. KATZ: Well, again I'm happy to work
24 with you. I'm still learning how to do the things
25 that you just said. I mean, some of it we have to

2 acknowledge and what I meant by Woodhull in the
3 beginning, for those people who haven't seen it, the
4 Harlem Hospital was recently rebuilt. It's
5 beautiful. It's an example of how you should build a
6 public hospital. It both respects the history,
7 phenomenal world from the Roosevelt era, the WPA
8 murals that capture African-Americans and their life
9 in New York and in the US. Beautiful. It's just
10 what you should do, respect the past. But build a
11 hospital in the future. Woodhull is I think 25 or 30
12 years old. It was built under a hospital design that
13 I don't think most people would today have chosen.
14 Unlike you go into Harlem, and the same is true of
15 Jacoby and it's the modern idea, you go into a
16 hospital lobby and you want it to be very high so you
17 get this feeling of space. Well, Woodhull was built
18 on a different idea, you walk in and it does feel a
19 little cramped. Can't fix that but we can fix the
20 ED. There's simply not enough space and part of the
21 problem will be solved by the movement of the
22 program that we looked at behavioral health to a
23 different floor. But I'm happy to explore with you.
24 Again, this is my overall message, we can do this.
25 We don't have to shrink and close and go away. We can

make a different decision that it may be that not every place will do everything but Woodhull is a vital place. Brooklyn itself is growing in overall population. Brooklyn has also lost hospitals, other hospitals. So we should really look at how we make the facility as great as all those Woodhull people are.

COUNCIL MEMBER REYNOSO: So now the facility space. Does Harlem Hospital have a higher enrollment after its renovation than it did the years prior to? Is there a difference? Do the renovations matter? Do they attract people, a modern hospital is it attractive to people or are they seeing patients coming in at the same decline or rate of decline as every other H&H?

DR. KATZ: I don't have it but even if and I will get you the exact numbers. Two things first, you want people to feel like they're getting quality care and the care that everybody else is getting. It's not psychologically good to be in a facility that's outmoded. That sends a message and it sends a message to staff as well. You don't want to build institutional hospitals that make people feel like I'm in this hospital because I'm poor. You

2 want to create hospitals that say my life is worth
3 the same thing as anybody else's life. So the moral
4 reasons alone, but certainly in other settings, I am
5 aware that when a new hospital opens it is certainly
6 what we found when we opened up Martin Luther King
7 Jr. Hospital in LA, a new hospital attracts people.
8 So there is value and there are ways of, you don't
9 have to knock them down necessarily, there are
10 creative ways and we should look at Woodhull and ask
11 ourselves what are those creative ways that we make
12 the space. I mean, the rooms themselves at Woodhull
13 are really nice. It's just that lobby that gives you
14 that. . .
15 COUNCIL MEMBER REYNOSO: I agree. So the
16 last thing is, the savings through attrition that
17 we've worked with on the past and obviously you
18 believe it doesn't make any sense. It makes sense to
19 me that if you have a primary care doctor or a
20 hospital that could take a call for an appointment to
21 a primary care doctor that you can see in the next
22 three days, that person or that doctor could generate
23 revenue for the hospital systems and for themselves
24 but if you don't have that person then the hospital
25 can't take advantage of it and then you're waiting 30

2 or 40 days and then you just don't show up so you
3 lose the opportunity. So I'm excited to hear that
4 from you because that was something that I was
5 looking at here the rate of attrition and it looking
6 like a highlight and not looking like it was going to
7 go up but it could just be the way that I was reading
8 this but looking at the plan and I just want to go
9 through and maybe the Chair can help me understand
10 it. It's on page, okay so I don't see the page here
11 but one of the graphs show that we are going through
12 attrition and it doesn't necessarily show that it's
13 an increase in 19 and 20 so I just wanted to get
14 clarity.
15 DR. KATZ: Well, again, what I can
16 promise you is that attrition was successful in
17 getting the budget targets met but at this point,
18 having met the targets, I'm committing to you to
19 working with you on what I would see as policy
20 oriented finances where you decide what remains not
21 based on attrition but based on the priorities of
22 this council, the mayor's office, the doctors and
23 nurses who work at H&H, we all work together to
24 decide that we are spending more in this area, less
25

2 in this area because that's what our patients need
3 not because someone retired.
4 COUNCIL MEMBER REYNOSO: So you're saying
5 not replacing someone for the sake of, if we don't
6 need a nurse and one retires and we don't need but
7 maybe we need somebody that does something else, we
8 could hire, we just want to be smarter about how we
9 do it. It's not just about replacing the person who
10 goes right away. But the headcount is at 44,768
11 which is very low and we're talking about a two year
12 run where we lost over 4,000 to 5,000 employees in
13 H&H. So just want to get your perspective on
14 headcount and what you think about that.
15 DR. KATZ: Again, I wasn't here but
16 circumstances were pretty extreme and I certainly
17 understand that the city which was very generous to
18 H&H said there were limits on what could be done and
19 the attrition was H&H doing its part and I think that
20 people did a great job but again you can't run long-
21 term an organization on attrition. That can't be a
22 long-term strategy. It can be a temporizing strategy
23 and I think it was very successful at that and the
24 people deserve credit for that but it can't be how we
25

2 go forward. We're not, the path to success of H&H is
3 not attrition.
4 COUNCIL MEMBER REYNOSO: Yes, well that's
5 all I wanted to hear because that 44,000 number is
6 already too low in my estimation and I just hope that
7 while you're in leadership we don't see that number
8 continue to go down because this means a lot more
9 than just the healthcare of the City of New York,
10 you're talking about employment of many people that
11 are extremely important in the City of New York and I
12 just want to make sure that we stabilize and move
13 forward and we grow out of this is what you said, and
14 we're going to grow out of this deficit. I'm excited
15 to see that but again I want to thank the Chairwoman
16 for giving me so much time. But very excited to be a
17 partner with both of you to really push H&H for the
18 future.
19 CHAIR RIVERA: Thank you. So I wanted to
20 go back to Workforce because I think that's really
21 important and according to the latest key indicator
22 report that you share at your finance committee for
23 your board of directors meeting, since November 2015,
24 so global FTE is full time equivalents at H&H has
25 decreased by 4,641 positions to. . . So how many of

2 these reductions occurred among consultants and I
3 wanted to know going back to the council members
4 question, which facilities experienced the most
5 attrition during this period?
6 DR. KATZ: So the consultants are
7 completely separate savings.
8 CHAIR RIVERA: Really quickly, and I
9 know, I'm sorry I asked you two questions but I'm
10 going to add a third one. If you could talk a little
11 bit about the layoffs that you made recently at the
12 central office and you said there's 35 positions
13 you're going to save X amount of millions of dollars
14 and kind of the decision that led to that.
15 DR. KATZ: Sure. So I'll leave it for my
16 CFO to see if we have attrition by facility. I don't
17 know if we do or don't. So the consultants are
18 separate. So the headcount are people like myself
19 who work for H&H. So I do think that to some extent
20 some of the least successful consultants were times
21 when people were using it as a work around to the
22 hiring freeze. So people wanted certain functions
23 done, hiring freeze prevented them from hiring
24 someone, so people hired instead consultants at
25 higher cost. My view has always been that the good

2 government answer is to work with people. If someone
3 says you can't hire someone because we're on hiring
4 freeze, you don't go and hire a consultant at a
5 higher wage. That won't happen with me at H&H I
6 don't support that. I'm not a survivalist. I'm
7 somebody who really believes in open government and
8 growing for the right reasons. There's no money
9 being saved in that and that's part of why it was
10 relatively easy to achieve large savings in
11 consultants when we found a function that we needed I
12 said that's fine but then let's hire somebody to do
13 that function and that will ultimately cost less
14 money.
15 CHAIR RIVERA: Have you increased savings
16 in terms of consultants since the last hearing? You
17 had a number that you had as a goal. You exceeded
18 the number that you had told me before the hearing
19 and since then have you made any further cuts?
20 DR. KATZ: Yes. But I don't have, I know
21 the consultants that I stopped but I don't have a
22 dollar. Do you have any of the dollar?
23 MR. ANTON: On the last time we met, we
24 indicated the number of consultants. The total
25 reduction if you'll give me a minute. . .

2 CHAIR RIVERA: I think you said $16
3 million.
4 DR. KATZ: So this week I eliminated
5 within two different consultants a scope of work but
6 that was literally this week and so I wasn't thinking
7 in terms of this hearing what would be necessary. In
8 one case it was a clinical function that I said that
9 should be done by our doctors and nurses. I don't
10 want outside opinions on how to do this I want our
11 own doctors and nurses to decide because that's the
12 only way it's going to happen. In the other case, it
13 was a survey of data that I knew would be no
14 different than it was two years earlier and I said
15 let's use the two years ago data, nothing's changed,
16 it's not worth spending the money. So that was
17 yesterday. What you have from me and I think my
18 staff understand this, the money is for the patients.
19 That's what we're here for. We're here to take care
20 of people so I'm all for spending money on doctors
21 and nurses and pharmacists and social workers and the
22 people who support them but otherwise I'm not in
23 favor of spending money. So things have to be
24 explained and there are explanations. IT is a
25 perfect example, the care of patients does depend on

2 high quality IT. So yes, IT, that doesn't mean that
3 I support all IT projects. I want to know how with
4 each project and I have a terrific chief information
5 officer, Kevin Lynch, who is here, I always refer to
6 him as the primary care doctor of IT because on day
7 three he was out at Belleview dealing with a
8 frustration that the doctors were facing with our
9 current system and fixing it. But even for IT, it
10 has to be if I agree to this expense, explain to me
11 how the care of my patients is going to be better.
12 So the 35 positions that we let go of last Friday was
13 not because we were overstaffed, it was not because
14 there was anything wrong with the job that the 35
15 people were doing, it was that the central office
16 functions to me are simply not as important as having
17 adequate staffing in our clinical areas and if has
18 happened to me as I've toured the facilities and I've
19 seen nurse ratios where I don't think there's enough
20 nurses and I've seen ED's where I don't think there
21 is enough coverage, how can I explain or defend to
22 anyone why I might have an administrative function in
23 central office. There's nothing wrong with that
24 function and in the difficult weeks leading up to
25 that, one of the things that I comforted myself with

2 is maybe we'll grow these back. I just have to feel
3 that I can't accept having an administrative position
4 if I can't deliver care. The first priority has to
5 be the care of the patients and so none of the 35 are
6 positions related to patient care.
7 CHAIR RIVERA: Alright, I want to ask
8 about correctional health. I know you have a time
9 stop and I want to be fair.
10 DR. KATZ: Patsy Yang is our head of
11 correctional health and she just knowing that I value
12 her input came up to the table in case there were
13 questions I couldn't answer myself.
14 CHAIR RIVERA: Alright so thank you. Let
15 me ask you really quickly about capital funding while
16 I still have my colleague here. So we talked a
17 little bit about your spending and spending about
18 $202 million of the plan, $881 million from 2017, I
19 want to know what can H&H do to improve its capital
20 planning and spending? I know you said you're
21 learning and we're all learning together but I want
22 to know what's really in the pipeline in order to
23 meet its commitment targets in the future fiscal
24 years because as you mentioned there is a lot of room
25 for improvement in terms of infrastructure that

2 hopefully bring in new patients but that will better
3 serve the existing patients. So what is the plan to
4 meet your targets and spend the money that's already
5 committed?
6 DR. KATZ: I think that the money hasn't
7 been spent because we're coming off of a year of
8 terrific interim that he very much saw himself as an
9 interim. He did a phenomenal job at that but that
10 because of that the organization hasn't had for a
11 while someone with a long-term commitment to the
12 organization which is what I have. And so I think
13 just decisions got deferred because the needs way
14 exceed that dollar amount which then requires
15 challenging decisions; do you do this hospital, do
16 you do this hospital, do you do this clinic, do you
17 do that clinic and because there hasn't been a steady
18 leadership those decisions haven't been made. The one
19 request that I ask of you is I'm not someone who
20 makes these kinds of decisions from central office
21 and so I know the people have waited and I feel bad
22 about that but I don't want to now say okay, well
23 Mitch thinks the five most important projects are. I
24 want to, with the council, with the mayor's office,
25 with the hospital people, really look at it and

figure out which are the things that are the most important to us and so what I can promise is that I intend to be here a long time and that once we're together on what the plan is, the money won't go unspent. To some extent I'd prefer that the money went unspent than it was spent on the wrong things because it's not lost to us. On the other hand, I get your point that people are going today and they're not benefitting today. One of the areas that I felt very strongly about and we're now working on is Belleview's psychiatric emergency room. It's from my point of view, a grossly inadequate to be taking care of people. It is too small. It's the wrong facility. It needs quite a bit of work. Now fortunately, there is a plan whereby we're going to move a group of people to an empty ward for observation so there is a plan but I've asked and again it's the most basic things, why is this environment look like a jail? Why is it painted institutional green? I understand in a ward for people who have psychiatric disease or are suicidal, you can't have things that people can just grab and throw at someone but that doesn't mean that you should paint everything institutional green. You

2 could have murals on the wall. For that matter, you
3 could have murals on the ceiling so if you're on a
4 gurney because you're not able to control the
5 movement of your body, there's something pleasant to
6 look up at. It doesn't have to seem like people are
7 in jail. And some of that is not so expensive. Some
8 of that is simply saying that these patients matter.
9 They're having a hard time at this moment. They may
10 need to be restrained but not because they've done
11 anything illegal, let's treat them in an environment
12 that's more healing. So I want to with you really
13 now look at the different facilities with an eye to
14 what do we want in the next five years and I promise,
15 at least, while it may be delayed, the money will be
16 well-spent.
17 CHAIR RIVERA: So, you know we all have
18 our priorities as council people in our
19 responsibilities to our constituents and I'm sure I
20 can speak on behalf of my colleagues in saying that
21 we will do whatever we have to do to expedite
22 conversations and making a list of priorities and
23 myself, even recognizing that there are hospitals
24 that have bigger needs than maybe the hospitals in my
25 own district. I'm willing to have that conversation

2 and talk about poverty and immigrant populations and
3 undocumented in places like Elmhurst that are
4 completely full and how we really have to look to
5 those places and put resources. So we will do
6 whatever we can to expedite those conversations. You
7 have that full commitment from us because I think
8 nothing is more important than your health. I want
9 to ask about the local health clinics and kind of
10 demystifying the process of applying for capital
11 funds for these more locally based clinics. So how
12 clinics in my district have recently applied and OMB
13 and H&H have denied their funding requests. So for
14 example, this is really Roberto Clemente Mental
15 Health Center which you mentioned before had a couple
16 of requests that were denied and it's an ongoing I
17 know and somewhat arduous and complicated process so
18 I wanted to ask if you could walk us through H&H's
19 centralized capital request process and for example,
20 what factors other than of course, cost and the
21 lifespan of the request itself do you consider when
22 you determine final eligibility for these projects?
23 MR. ANTON: So let me start by saying
24 that we cancelled the report on H&H was really well
25 written and actually gave me insight into it and

2 outside perspective and it notes very nicely that our
3 commitment last year has gone down significantly and
4 as Dr. Katz pointed out it was clearly the reason of
5 looking more strategically where H&H was going and
6 our focus turned away from capital and focused more
7 on normal reconstruction work and of course our IT
8 projects are a large part of it. So and you also
9 know that the history of H&H is that it used to be
10 five separate networks. They all made individual
11 decisions on their own and by converting it to a
12 network basis to a system took a lot of work at
13 central office to bring collaboration to everybody to
14 get to the place of really evaluating a business plan
15 for all capital projects. So we've actually come up
16 with a process and right now that if any of the
17 facilities want to invest in capital equipment that
18 they should go through a process of evaluating what
19 it would cost, what the returns are expected added,
20 in terms of improved patient care, improved revenues,
21 operating expenditures, so there is an entire process
22 that has been set up and it is just rolling out. So
23 we just made that available. We also have invested
24 in a system wide accounting system and a budgeting
25 system that will allow us to look at what the

requests are from all the facilities and make assessments based on the information that they provided. So it's at the beginning stages of it so I can't give you an update on that particular capital project that you mentioned but clearly we are on our way to having a structured approach to this.

CHAIR RIVERA: Okay, great. Alright, so I wanted to get into correctional health and I wanted to ask if you plan on answering any of the questions to of course administer the oath. So do you affirm to tell the truth, the whole truth, and nothing but the truth in your testimony before this committee and to respond honestly to council member questions.

MS. YANG: Yes I do.

CHAIR RIVERA: Okay, so the fiscal 2019 preliminary budget included increased funding for correctional health services that's in Brooklyn, Staten Island, the Bronx, and Queens and the planned funding increases from $3.9 million fiscal 2019 to $6.3 in fiscal 2020 and $7.4 million in the out years. So how is CHS going to use the increased funding to expand its operations over the course of the plan and what's the timeline for implementation?

2 MS. YANG: Thank you. That budget,
3 correctional health has been very fortunate since it
4 moved over to H&H in terms of city investment by the
5 mayor and the council to improve and enhance our
6 services. This most recent funding will allow us to
7 expand a number of critical programs, one of which is
8 the Naloxone distribution that Dr. Katz mentioned,
9 currently is being done only at Ricker's at the
10 visitor center. It will allow us to expand it to all
11 the other borough jails so we'll be doing the exact
12 same thing we're just training people who come and
13 visit people their loved ones in the jails so that
14 they can also have Narcan. Another one is our
15 enhanced pre-arraignment screening which we started
16 in November of 2016 in Manhattan as Dr. Katz also
17 mentioned. This started as a pilot program on our
18 part to replace what is currently a stipulation on
19 the city to do a pre-arraignment screening on
20 individuals who might be at risk of a medical
21 condition that needs emergent attention. Right now,
22 in the rest of the city, except for Manhattan, it's
23 being done by EMTs. Our proposal which has just been
24 funded will allow us to expand our enhancement
25 proposal which has clinicians, nurses, and in

2 Manhattan we went 24/7 in this program in November
3 2016 and just in that first year of operation we
4 screened over 53,000 people just in Manhattan 24/7
5 and we reduced by almost one-quarter the number of
6 people who would have otherwise been transported to a
7 hospital emergency department which would have
8 clogged up the emergency departments but also
9 commanded resources from fire department EMS and New
10 York Police Department in terms of escorting people.
11 It would also disrupt their judicial processing
12 during the arraignment process. The pre-arraignment
13 screening program has also been really, really
14 efficacious in that it allows us to identify people
15 who may have conditions, social/behavioral, mental
16 health, substance abuse conditions which with client
17 consent, we provide to the defense who bring that
18 information to the case before the judge that can
19 sometimes result in better outcomes, better
20 dispositions, alternatives to incarceration,
21 diversion centers, treatment centers. And finally
22 the other good thing about the pre-arraignment
23 screening is that it allows us to identify people who
24 may be at high risk so that if they do end up in jail
25 we'll know to expedite them through intake, we might

2 know that they might be detoxing, they might be
3 diabetics who need insulin. We can identify them
4 before they get in to jail. So that's actually
5 expanding from Manhattan to over the next few years
6 to Brooklyn, the Bronx, and Queens, the other borough
7 houses that we think will be really significant in
8 terms of diverting people to alternatives and
9 reducing risk of death or bad outcomes. The other
10 programs that we're also getting are to improve
11 mental health services for women in jail and that's
12 everything from standing up a program for screening
13 and connecting them with safety planning for women
14 who may be at risk for intimate partner violence to
15 bringing some mental health services to women who are
16 in our medical infirmary. It's programs like that.
17 CHAIR RIVERA: I want to ask specifically
18 about Riker's Island and I have some questions that
19 I'm going to ask the Department of Corrections but
20 first one of the adjustments in the fiscal 2019
21 preliminary plan it concerned the purchase and
22 installation of a modular trailer on Riker's Island
23 that was going to provide program space for CHS. So
24 I have a question as to why H&H used expense funding
25

to purchase the trailer which is $1.6 million dollars rather than secure capital funding for the purchase?

MR. ANTON: The capital review process on that goes through Bond Council at OMB and it was probably deemed ineligible for a capital funding. Anything that the minimum requirements on a capital project require certain life on the project itself and mobile equipment and modular furniture don't necessarily effect those criteria.

CHAIR RIVERA: Oh, you're saying you chose to use expense because the trailer wouldn't last five years?

MR. ANTON: I'm saying this as more of a guess from my past life than actual knowledge about it but I know for certain that OMB would almost always prefer to use capital funds over expense dollars so the only thing that comes to mind in terms of why they would not have chosen that option would be because it did not satisfy the life. Clearly the dollar value of that we're expending on that is sufficient for capital guidelines but we'll follow up and see if that is something to be changed.

CHAIR RIVERA: Yeah, if you could follow up because I just ask that we just discussed capital

2 funding, eligibility, criteria, what groups and
3 organizations have to go through and I just ask that
4 you apply this same criteria to your own purchases
5 that you do outside organizations that are also
6 trying to help the community. So the plan also
7 allocates $86,000.00 in fiscal 2018 and $79,000.00 in
8 fiscal 2019 to educate direct care providers on
9 linkages to pediatric, endocrinology, and other
10 transgender youth medical services as part of the
11 Unity Project the city's first multi-agency strategy
12 to enhance services for LGBTQ youth and currently how
13 many direct care providers at H&H are equipped to
14 address the endocrinology needs of transgender youth
15 and secondly, how many trainings will the funding
16 support and how many providers will it reach and can
17 you also speak to how this kind of project is being
18 implemented or being used at correctional health
19 facilities because of the LGBTQ community?
20 MR. ANTON: I don't believe it is part of
21 the correctional health services program. It is. . .
22 CHAIR RIVERA: It specifically LGBTQ
23 youth, transgender community, and how you're
24 addressing some of those health needs and some of
25 also the issues that happen in that population.

DR. KATZ: I think chairperson, I'll have to get back to you on some of the exact notes. I mean I've taken care of many transgender people in my career as a primary care doctor and so most internists and most pediatricians would be capable of doing hormonal therapy. I know that H&H has several really fine centers for the care of LGBTQ, people, youth. I'm very proud to find that New York City has it. I can't say that I have detailed data. I'm looking so I would have to on the number of patients, number of providers, I'd have to get back to you on that.

CHAIR RIVERA: I'm going to ask if my council member has a question. Council Member Steve Evan.

MR. EVAN: Thank you very much Chair Rivera. Thank you all for your testimony. I wanted to follow up on the questions that I had at our last hearing a couple of weeks ago regarding efforts around confronting the opioid epidemic in New York City and what role H&H plays in that. Is there any RY19 allocations or new budget lines or new initiatives in the preliminary budget under H&H that are designed specifically to confront the opioid

2 epidemic looking at what they're doing elsewhere,
3 other cities, other jurisdictions?
4 DR. KATZ: I know we're set to expand
5 programming. I can't answer is there a dollar. . .
6 MR. ANTON: I don't have any answer at
7 this point but I can get back to you on that.
8 MR. EVAN: Okay, I mean what I would like
9 to see in the executive budget is some new
10 programming, it could be pilot programming really
11 exploring ways in which H&H can partner with DOHMH on
12 some of the things that they're doing over there.
13 Obviously looking at some of the policy
14 recommendations whether it's safe injection
15 facilities which we're hoping the mayor comes out in
16 support of in the coming days. Or other harm
17 reduction models or and as we talked about in our
18 last conversation increasing access to long-term
19 medical treatment, medical intervention, whether it's
20 through methadone or buprenorphine and then also
21 advancing peer-to-peer counseling, particularly when
22 people are overdosing and going into H&H emergency
23 rooms. So those are the types of things I would hope
24 that there might be some new resources in your
25 executive expense budget to try to scale up some of

2 those or pilot some of those. But at the moment, in
3 your prelim, nothing specifically designed to do
4 that?
5 DR. KATZ: That's correct. What I would
6 say is that I can't think of anything of more
7 valuable to spend that money on. So regardless, to
8 some extent there is no, if a new drug gets approved,
9 I don't mean opiates, there's no specific allocation
10 for X new drug but we all start using it. We're in
11 the midst of this epidemic that's killing people.
12 MR. EVAN: Every seven hours in New York
13 City. Every seven hours someone dies.
14 DR. KATZ: We should use every resource
15 we have but we don't need a separate line item.
16 MR. EVAN: Right, I mean for some of
17 those kind of pilot programs if you're going to be
18 paying peers to be in emergency rooms that money's
19 gotta come from somewhere and they gotta have a
20 supervisor and they gotta have wrap around service,
21 the fringe and what not. So I would hope to see
22 maybe some, even if it's relatively modest, I would
23 love to see something in the executive budget that
24 says this is going to be some new funding dedicated
25 within the H&H budget because there's a huge

2 coordinating. . . I mean, like frankly, like last
3 year in the healing NYC plan, H&H is put forward and
4 the backbone for that medical service delivery in the
5 future. It's not even DOHMS as it's H&H is the one
6 that's going to be taking on a major role in that and
7 when I talked to homeless service providers they have
8 a lot of questions about how they're going to be
9 working with H&H to ensure that there's access to
10 long-term medically assisted treatment, so on and so
11 forth.
12 DR. KATZ: Understood. Thank you, I
13 fully agree.
14 MR. EVAN: Okay, so let's maybe work on
15 that and see if we can get some new budget lines in
16 the executive budget.
17 DR. KATZ: Excellent.
18 MR. EVAN: That would be great. Okay,
19 thank you. Thank you Chair.
20 CHAIR RIVERA: Of course and I just,
21 Steve Levin has joined us as has my colleague
22 Francisco Moya and I just want to say we saw an
23 independent budget office report that said from 2009
24 to 2014, mental health hospitalizations at H&H had
25 increased by 20% while mental health hospitalizations

2 at voluntary hospitals had decreased by 5% so it's
3 clear the need is there and people are going to H&H
4 and the reimbursement for those hospitalizations are
5 very, very low. So when you do come back to us with
6 the fleshed out seven point plan and whatever it's
7 going to look like, please real dollar commitments to
8 serving this vulnerable and important population that
9 continues to come to our city's health system for
10 service. So I just wanted to underline that and say
11 Council Member Moya, you had a question?
12 COUNCIL MEMBER MOYA: Thank you Madame
13 Chairwoman for your great questions and to president
14 Katz, thank you once again for being here. Just two
15 quick questions. In your testimony you spoke about
16 the renovation and expanding the adult emergency room
17 at Elmhurst Hospital. Can you just walk me through
18 what the phases are going to be? Do you have that
19 information? Does anyone have that information?
20 MR. ANTON: We do have it. It's built
21 out into four phases and I'm trying to find it as we
22 speak. They're going to start off with the adult ED,
23 move onto the pediatric section, build out a CPAP
24 unit, and then circle back and build out the balance
25

2 of the adult ED. So that was about, I think the
3 project is about $30 million dollars or so.
4 CM MOYA: Right, and when is the start
5 and finish?
6 MR. ANTON: I think it is at the facility
7 right now finishing up the design stages. Once
8 they're done with that they will reach out to central
9 office and Dr. Katz for consultation to make sure
10 everything is in keeping with the rest of the
11 organization and then we'll move on beyond that.
12 CM MOYA: Will you please keep me
13 informed of what that looks like given the fact that
14 that emergency room as you all know, busting at the
15 seams and what kind of disruption that may have on
16 the impact of people going there because that's
17 really important to know the timeframe and it's very
18 welcomed that we're having the expansion that comes
19 in. Also, in fiscal 2018 to 2022 in the preliminary
20 capital plan which includes $2.5 million for Elmhurst
21 to replace its equipment to renovate the facilities
22 suite including $500,000.00 this fiscal year. The
23 angiography equipment, the plan also includes $2.3
24 million to construct a women's health pavilion at
25 Elmhurst. Can you provide status updates on these

2 capital projects and also how do these projects and
3 other capital projects in the plan inform your vision
4 for Elmhurst moving forward?
5 MR. ANTON: Is it okay if we got back to
6 you on that?
7 CM MOYA: Please. Thank you so much.
8 Thank you Mr. President and thank you Madame
9 Chairwomen.
10 CHAIR RIVERA: I would say every time you
11 come here just prepare for a question about Elmhurst
12 and anything in any of the other council members
13 districts just be ready. Just have everything on
14 hand. So thank you CM Moya for your question and
15 how important Elmhurst is to our H&H system. So just
16 to go back to some of the questions I mentioned
17 earlier that I had asked the Department of
18 Corrections during the criminal justice committee
19 hearing. How many correctional health staff are on
20 Riker's Island?
21 MS. YANG: We currently have about 1,651
22 FTE's. I'd say all but about 120 are either on
23 Riker's Island or in the borough houses. We don't
24 consider the nine jails on Riker's separate from the
25

three borough jails it’s one large system and our staff move from one to another as are needed.

CHAIR RIVERA: Oh, I see, so you consider them all together?

MS. YANG: We’re one correctional health system.

CHAIR RIVERA: Right. Okay, I appreciate that. So how many times a week does Department of Corrections and H&H staff meet?

MS. YANG: On a daily basis and at multiple levels. Certainly at the jail facilities themselves we encourage problem solving so there’s the clinic captains, the warden’s, our health service administrators, our supervising medical directors, and our directors of nursing. There’s that core team. There’s people actually in each clinic who meet every day. Then there’s the middle levels around particular issues or standing meetings and then there’s the executive leadership.

CHAIR RIVERA: Do you think that the Department of Corrections staff is adequately trained in terms of mental health needs and identifying mental health consumers?

2 MS. YANG: We have been working together
3 to do more training and it’s not just on mental
4 health and identifying people who are both staff and
5 patients who may need some attention but we’re also
6 doing increasingly more joint training since coming
7 over to H&H on de-escalation, on managing patients
8 together and de-escalating situations rather than
9 letting them escalate on their own.
10 CHAIR RIVERA: And when Riker’s Island
11 does close, what is the plan for the mental health
12 population that’s on the island?
13 MS. YANG: The mental health population
14 is a large one and any individual patient’s needs for
15 services and placement will vary and fluctuate. A
16 patient can deteriorate or improve and that will
17 dictate the services that we provide, the clinical
18 services that we provide. We are envisioning that
19 there would be mental health patients and varying
20 types of mental health services and housing units in
21 every one of the four jails that are anticipated at
22 this point in time. We think it’s as important, the
23 question here of cohort or catchment, whether people
24 are jailed by who they are or what clinical condition
25 they may have versus where they live or their borough

of adjudication and arraignment. Those are still questions that the City is grappling with with input from all stakeholders. We are part of that conversation but we think that because you have a particular condition with some exceptions, some particular clinical exceptions, people should benefit to be as close to their family as anybody else.

CHAIR RIVERA: So before the plan to close Riker's Island was made public and there was I guess a somewhat clear timeline DeBlazio, our mayor had mentioned building a state-of-the-art jail just for mentally ill patients and since now we've kind of scraped that plan, what is your assessment of the adequacy of the facilities on Riker's and of course in the borough jails as well?

MS. YANG: The facilities are old, I think we all know that and to varying states of good operating and disrepair. This is not a modern physical plant in any of the twelve jails that are in the city and by 12 I include the barge in the Bronx and so there definitely needs to be physical improvements. They're by no means modern rehabilitative environments.

2 CHAIR RIVERA: So we've started the
3 process of planning for a new jail system. We're
4 going to a more localized system because of the
5 failure of Riker's Island and for a number of other
6 reasons in that I think a lot of us believe that you
7 are in a better place for rehabilitation if you are
8 closer to home, closer to services, etc., and I think
9 we all share those beliefs and values. So with this
10 process of planning for a new jail system and closing
11 the facility that's on Riker's Island, the
12 administration has hired consultants to engage
13 communities and begin the land use process and the
14 mayor's office of criminal justice has convened a
15 task force to guide policy decisions. So given the
16 sizable population again of the mentally ill New
17 Yorker's in our city's jail system, what role do you
18 see CHS playing in the closure of Riker's and the
19 placement of these individuals?
20 MS. YANG: We're absolutely foundational
21 and have been asked to participate in that way.
22 We're a critical partner.
23 CHAIR RIVERA: Does your long-term plan
24 include a vision for jail based healthcare?
25 MS. YANG: Yes.

CHAIR RIVERA: And at the new facilities?

MS. YANG: I'm sorry.

CHAIR RIVERA: At the new facilities as well.

MS. YANG: Yeah, wherever our patients are we will be.

CHAIR RIVERA: Okay, and we just want to again offer our support in these conversations because I for one, think that there are a lot of people who are in jail right now who do not have the right medical assessment and who are not receiving proper and quality care and I know you're only as good as the resources that you get so when you mention that the facilities are in disrepair and we do have capital funds that could perhaps be prioritized for some of these patients, I really want us to work together in putting together some priorities. So thank you for that. Alright, so just one last question about this. I know that we've talked a lot about this and I want to thank Levin of course for opening the door in terms of discussing mental illness and how important it is in the H&H system and we'll probably have a hearing just on this in April because it's so so important I think to the

2 future of New Yorker's. So at least 11% of the
3 inmates in our city's jail system reportedly have
4 severe mental illness, schizophrenia, bipolar, PTSD,
5 post-traumatic stress disorder, so what is the
6 connection between the psychiatric patients in the
7 H&H system and the seriously mentally ill in the
8 city's jail system?
9 DR. KATZ: Well, I know this one which is
10 that it is the same people going back and forth and
11 that one of the things that's very important to me to
12 work on together is that I see in the current system
13 for both mentally ill people and people who are
14 addicted a whole and the whole is something between
15 inpatient acute services and outpatient services
16 because most people who have serious mental illness
17 and drug addiction, especially if they're homeless,
18 are not going to be able to benefit from outpatient
19 services. Outpatient services are a very reasonable
20 way of taking care of people who have a home and who
21 have support, they're working, it's the right thing,
22 you go to your meetings before work, you go to your
23 meetings after work, I think that's terrific and I
24 think there's actually research to say for people
25 with jobs and good support systems, you're probably

2 better off in outpatient and not residential but in
3 the case of people who are homeless, people who are
4 in unsafe settings, to me the lack of something in
5 the middle is a huge problem and I'll just give you
6 one example when I was touring, I think I was at
7 Lincoln, and there were a group of five people
8 sitting fully dressed in the emergency department.
9 So I said to the emergency room doctor that's strange
10 they kind of look like visitors but they're here in
11 the patient section. He said they're waiting on
12 their urine tox screen. I said why. He said for
13 detox. So it turns out that by New York State Law in
14 order to enter detox you have to have a positive
15 urine showing that you've recently used. So I'm like
16 you mean if someone is seriously addicted and they've
17 been fighting their addiction for two days and
18 haven't used and they're coming to us because they
19 realize they're about to start using, we're going to
20 deny them treatment and the answer is yes. You have
21 to have a positive urine to enter a licensed detox.
22 Well, so we need to create a different service model
23 that is not sensible. If somebody is seeking
24 treatment for their addiction, we need to treat them.
25 We don't want to be saying you have to go shoot up

2 outside so that we can take you into our treatment
3 but at the same time, detox is a service is not, most
4 people when they're finished detoxing they're not
5 going to be able to live the rest of their life in
6 sobriety. They're going to go back out and they're
7 going to return to the same life that they had before
8 and they're going to start using again and the same
9 about inpatient mental health, if you take somebody
10 with serious psychosis, you can use inpatient
11 psychiatry to change their treatment but if they're
12 then going back to living on the streets or in the
13 shelter, they're going to get worse again. So we
14 need long-term, like three to six month settings to
15 care for people with serious addictions and serious
16 mental illness because otherwise they end up back in
17 jail and I think that if we can create these three to
18 six months periods of good milieu treatment and
19 medication you will see that the number of people
20 with serious mental illness in the jail system will
21 decline.
22 CHAIR RIVERA: Let me ask you about
23 substance abuse. Of course, there's the inmate
24 population, there's of course trying to decrease
25 recidivism and getting them proper care and I

2 appreciate your comments on how health is so
3 important you feel in terms of holistic approach to
4 someone's well-being. I wanted to ask about opioid
5 abuse. There was a very good hearing, a very long
6 hearing here at the council about it because of the
7 numbers and the cases that we're seeing here in New
8 York City and we saw Kaiser Health News recently
9 profiled Colorado's alternative to opioids projects
10 which is just an effort to limit opioid use in
11 emergency departments. So the ten hospitals that
12 participated in the project were able to reduce
13 opioid use by 36% over six months. So as H&H system
14 explored similar strategies for limiting opioid use
15 in its ER's and for example they mention using safer
16 and less addictive alternatives to opioids such as
17 Ketamine and Lidocaine.
18 DR. KATZ: So, yes, H&H has been engaging
19 in a variety of initiatives to decrease opioids but I
20 think there's a way big distance to go. I think the
21 ED's are just the tip of the iceberg and in fact
22 those people are already addicted, the people who are
23 seeking opioids in ED's they're addicted, that's why
24 they're seeking the opioids in the ED's. So they
25 need the appropriate treatment and one of the things

that makes me happy is that our emergency doctors are now able to prescribe buprenorphine and are thereby able to start treatment. Where I think there's a huge hole in what I think the research over the last two years has shown is that for some people biologically one short prescription opioid treatment which seems like a fairly minor thing, does lead to addiction. That people may get seven days because of a tooth that's pulled or a broken bone, not everybody, but I think five years ago it was assumed that those prescriptions had nothing to do with the opioid epidemic that everything, the initial thinking was what we need to do is to get doctors to stop prescribing for a month or two months or three months but the newer research suggests that to some people a seven to ten day prescription is enough to turn their brain biology, they have no control over it, this is physiologic as blood pressure, that they then become hooked. So part of the effort has to be both to get doctors and patients who have not used opioids in the past to not use them which requires for both sides a sort of change in the mentality and I know I've changed my own primary care practice from the point where I used to think you know someone has a bad

2 toothache, I'll help them over the next three days.
3 I don't want people to be in pain and I still don't
4 want people in pain but I completely look at it
5 differently now and I tell people that. I say you
6 know I know it really hurts and it's not that I don't
7 want to give you something that relieves the pain but
8 we've found that a number of people who've never
9 taken opioids before, when given this first
10 prescription if you follow them up at a year, a
11 shocking number are taking opioids chronically and so
12 you know I really want you to try, I know you're
13 miserable, but I'm going to prescribe some ibuprofen.
14 I really want to use distraction and figure out how
15 you manage it. I had a patient who did really well
16 with his Gameboy and he taught himself whenever his
17 pain happened he would start playing on the Gameboy.
18 There are other strategies. I think that if we're
19 thinking about H&H of the future, there are other
20 modalities like acupuncture and sensory treatments,
21 we're not currently outfitted to do those things but
22 acupuncture is a very effective treatment for pain.
23 No question and there are other methods, physical
24 therapy, chiropractic care, electric stimulation,
25 cognitive behavioral therapy, I mean there are a

2 variety of other tools and so it would be nice if we
3 had for the doctors and their patients other tools
4 and that’s something I intend to work very hard on in
5 the next year.
6 CHAIR RIVERA: I look forward to hearing
7 about that because I agree, I think that if we
8 explored, and I mentioned holistic medicine earlier,
9 I think there’s alternatives that H&H does not
10 provide and people seek private providers and they go
11 to other places and while we could really make it a
12 one stop shopping at H&H and no matter your
13 background or your beliefs in medicine and
14 prescriptions so thank you for saying that. So I did
15 want to. . . I guess I’ll just ask you a couple more
16 questions. I know, I didn’t want to make the hearing
17 too long and I do have a number of other questions
18 that we are not going to get to. So what I would ask
19 is if I can send you some of these concerns and these
20 questions that we have and you’ll have an opportunity
21 to take your time to respond to them in depth and of
22 course I want to underline the transparency because
23 Dr. Katz if I showed you some of the reports that
24 we’ve gotten in the past you would not find them
25 acceptable.

2 DR. KATZ: I have seen them and I'm not
3 here to defend them.
4 CHAIR RIVERA: Okay great. So the
5 primary care physicians, I wanted to ask a little bit
6 about that and the partnership that you have with
7 some of the, I guess local institutions. So you've
8 identified the need to invigorate and expand primary
9 care is one of your top priorities for the H&H system
10 which I completely agree with. How do you plan to
11 address the fact that the United States in general,
12 the country, is going to face a significant shortage
13 of physicians particularly primary care doctors in
14 the coming years.
15 DR. KATZ: Well, I appreciate your
16 asking. One of the things that I think we underuse
17 and I want to make a big push in H&H is for the
18 greater use of pharmacists. People don't always
19 appreciate that pharmacists are people who have a
20 Ph.D., professional level degree in pharmacology.
21 Primary care doctors like me, we took three months of
22 pharmacology, they study it for four years.
23 Pharmacists cannot diagnose so when I'm in primary
24 care, I would be the person who would say you have
25 diabetes, you have hypertension, you have elevated

cholesterol but a system can then create what are called pharmacist physician treatment plans that say, we had these in Los Angeles with tremendous success. You may know that Los Angeles is probably center one of the epidemic of diabetes because it's much higher in Latinos of Mexican decent. So a very common patient in my East LA clinic would walk in with a blood glucose of 500 which is like five times normal and they were actually feeling okay, maybe they were feeling a little weak and didn't know why. So there is an established protocol of how you would, what the next medical treatments are and it takes to get someone with diabetes that high into control is about six or seven visits. But they don't need to see me. I've already diagnosed their condition, they have diabetes. They need a set of medication increases and the people who are best set to do those are pharmacists. They also need nurse education. They need a nutritionist. So part of the solution is to really look differently at your work force and I feel the same about community health workers. Doctors like me should not be trying to teach middle aged people how to cook healthier food. I can only microwave. Nobody would want to eat the dinner that

2 I would prepare. Why does the world expect me to
3 coach a diabetic on how she should cook her families
4 meals. You should get a woman who's a diabetic who's
5 figured out how to cook her families meal to teach
6 others on how to do it and we have little pockets of
7 this in H&H but my whole thing is anything can do a
8 demonstration project. I'm interested in scale.
9 That's what I love about big systems like New York. I
10 don't want a cooking class in one hospital in one
11 clinic. I want to know that everybody who has
12 diabetes learns how to prepare food in a healthy way
13 for them and their families. That's how it's
14 supposed to be. So I think that we can get beyond
15 the shortage of primary care doctors if we ask
16 doctors to do doctoring and we ask nurses to do
17 nursing and we ask pharmacists to take care of the
18 medications and I think we'll actually add, and I'd
19 add social workers to take care of the eligibility
20 that people need to get on the appropriate snap
21 program, to get the income credit because economics
22 affects people's health, so as you would say, it
23 requires a holistic care and holistic care is best
24 delivered by a team, not all by one doctor. I should
25 add those visits are all reimbursable under

2 insurance. This is a viable plan. I'll see that
3 plan. I'll tell that I'll see you back if you have
4 any new symptoms but your next four or five visits
5 are going to be with the pharmacist and the nurse
6 educator and the nutritionist and I'll be following
7 your progress.
8 CHAIR RIVERA: I made a note her to send
9 you a cooking basics book.
10 DR. KATZ: It would be hopeless.
11 CHAIR RIVERA: Okay, alright. So are you
12 in partnership or I guess contract with local medical
13 schools to bring PCP's into the system?
14 DR. KATZ: We are. We have with NYU,
15 Mount Sanai and also the affiliate Pagni and we hire
16 ourselves and I think hiring itself is something that
17 H&H could do a better job. We run amazing clinics.
18 If you were a doctor how would you know that? We
19 have, what I've discovered is almost nothing that
20 would enable you to know that there is a Roberto
21 Clemente Clinic and why you would want to work there.
22 I mean community clinics are very special places but
23 all the job offers just go on some uniform website.
24 That's not how doctors choose where to work.
25 Doctors, nurse practitioners they choose to work

2 because they have some connection to a community,
3 someone has explained why this community is so
4 important, that hasn't been part of the fabric here
5 and that has to change. That's how you recruit
6 doctors.
7 CHAIR RIVERA: So I will ask that you
8 consider CUNI, it's a public system. These are
9 people who do a lot of commuting who are from New
10 York City and what I've seen a lot in this
11 administration is talent coming from other places and
12 you returned home so you get a pass.
13 DR. KATZ: I get a pass. I'm a Brooklyn
14 boy.
15 CHAIR RIVERA: Exactly. What I'd love to
16 see is us hiring from the New York City pool of
17 talent that is so clearly here and present. So I
18 just want to encourage you to look at CUNI and other
19 local institutions and I know that you've mentioned
20 NYU and Mount Sanai but we have some great public
21 systems and I'd love for that partnership to develop.
22 DR. KATZ: Thank you, terrific.
23 CHAIR RIVERA: So before we go to the, I
24 guess we have a few people here to speak and I
25 encourage you, if you'd like to give testimony,

2 please fill out a slip at the back with the Sargent
3 at arms. I just wanted to underline, I wanted of
4 course to thank you for your testimony today. I know
5 that I'm going to see you again in a couple of months
6 and at various topics throughout the year. Just know
7 that this committee is not just focused on H&H and
8 the public system. We are also focusing on the
9 voluntary hospitals and their responsibility and
10 their commitment to the city. We know that
11 unfortunately there is a burden that is on H&H to
12 serve the underinsured, the uninsured, the
13 undocumented, and everyone else that these primary
14 facilities unfortunately have a reputation for not
15 accepting. Having said that we want to be a partner.
16 We want to work with you and we ask that the same
17 responsibility and what people ask of me in terms of
18 transparency and accountability that you all
19 practice, I'm feeling good about new leadership in
20 both these positions and that we'll grow and develop
21 together. I will ask in a good faith effort for you
22 all in terms of our new relationship and the
23 increased communication that we ask that if you could
24 in terms of some of the reports that you've provided
25 in the past, whether you could give me a quick status

2 update on a couple of reports. One of them is a cool
3 based and cash based financial plans. Of course, the
4 more detailed budgets we'd love to see for example,
5 budget lines for district funding and consulting
6 fees, more comprehensive correctional health services
7 reports, and of course an updated transformation plan
8 that takes into account your new vision and your
9 conversations with all the stakeholders that are even
10 just in this room. So we'd love to see that as soon
11 as possible so we can prepare to have a more robust
12 conversation and to not keep circling on some of the
13 things that we've mentioned in the past two hearings
14 and just wanted to ask maybe a quick what has your
15 team done so far on some of these reports in terms of
16 where you are and whether we can have some of that
17 information and when do you think?
18 MR. ANTON: So on the accrual based
19 budgeting, it is an issue that has plagued H&H for a
20 long time. It is the lack of a viable financial
21 system has not allowed us to build something along
22 those lines but now, with our ERP system, we are
23 getting closer to that. The accrual budgets that we
24 put out to date are estimates based on our cash
25 system and that is available today but it doesn't

necessarily provide you any more information than what you have in the cash system and clearly living dollar to dollar allows us to sort of focus on cash for operating expenditures. As we get to a more stable place I think we can get you an accrual budget that'll be more meaningful. So we can work towards that. I don't think there is anything that is keeping us from doing that. We can work with the council staff and I've worked with them for a long time to know what their hopes are and we can do that.

CHAIR RIVERA: Okay, and so the detailed budgets including the consulting fees, budget lines for district funding, I just want to make sure that you have all that written down and comprehensive CHS reports really making sure that we're communicating and I plan to have a joint hearing with the criminal justice committee but I'd love that information well before hand.

MR. ANTON: Very good.

CHAIR RIVERA: And then finally of course the updated transformation plan. I know we're two and a half months in so I know that there's a lot of work to do and I really want to consider you all a

2 partner going forward and again anything you need
3 from us, we'll try to reciprocate.
4 DR. KATZ: Thank you.
5 CHAIR RIVERA: Thank you so much for your
6 time today and safe travels.
7 DR. KATZ: Thank you.
8 CHAIR RIVERA: I'm sorry I'm going to
9 miss you at the Belleview Legislative breakfast.
10 I'll let them know I was born there.
11 DR. KATZ: Next breakfast.
12 CHAIR RIVERA: Thank you everyone who is
13 here who has stayed with us. I know that not only
14 did we have a delayed start, you have waited
15 patiently so I'm going to call up the first panel.
16 I'm going to call up Erica Lessam from TAG, Claudia
17 Calhoun from NYIC, and Andrea Bowen. And thanks
18 again for your patience. Thank you for being here.
19 So we have a clock just to your right of time. If
20 there's anything, I don't want to stop you in the
21 middle of your thought just complete your sentence,
22 your thought and let's work together. So thank you
23 so much.
24 MS. LESSAM: Thank you so much Chair and
25 to all the H&H committee members for your commitment

2 to making New York a healthier more equitable place
3 and for the opportunity to call your attention to the
4 growing threat of Tuberculosis in New York City. My
5 name is Erica Lessam and I'm from Treatment Action
6 Group. Treatment Action Group is an independent
7 activist community based research and policy think
8 tank fighting for better treatment for HIV and
9 related conditions like TB. We at TAG and our
10 partners are alarmed by TB's recent rise in New York
11 City. TB is airborne and infectious meaning anyone
12 who breaths is at risk of contracting this
13 potentially deadly disease. But TB
14 disproportionately affects the most vulnerable; those
15 with weak immune systems, people living in crowded
16 settings, and our immigrant communities. Despite
17 being preventable and curable, TB is on the rise in
18 New York City for the first time in over 25 years.
19 This resurgence of TB is a direct result of years of
20 underinvestment in New York City's TB response.
21 While in recent years the city, thanks in part to
22 your leadership, has steadily funded TB. A history
23 of cuts since 2007 have reduced the city's TB funding
24 by half. Several of the city's TB clinics have
25 closed and the few that are still open have much more

2 limited hours and staffing. This failure to
3 adequately fund TB places a large burden on New York
4 City hospitals in addition to causing preventable
5 suffering and inequities. The majority of TB cases
6 in New York City are first identified in hospitals.
7 This means that we're failing to prevent TB and find
8 it earlier in our communities and to treat it before
9 people become very sick and require hospitalization.
10 It also means that when people do have symptoms,
11 they're not going to New York City health department
12 chest clinics. This is in part because so few chest
13 clinics remain. Once people are in hospitals those
14 who are infectious must be placed in expensive
15 isolation wards to keep the disease from spreading.
16 Over half of New Yorkers with TB are uninsured which
17 places an even greater financial burden on hospitals.
18 People who are hospitalized for TB also require
19 evaluations upon diagnosis and prior to discharge to
20 review their charts, assess if their home environment
21 is safe to return to, and identify contacts needing
22 evaluation for TB but public health advisors staffing
23 have been cut which places further burdens on
24 hospitals, meaning patients have to stay there longer
25 until they can be appropriately assessed and

2 released. Investing in the public health response to
3 TB now will save billions and alleviate a huge burden
4 on New York City's hospitals. Adequate funding would
5 allow for active outreach by community organizations
6 to prevent people from entering hospitals with TB in
7 the first place and it would allow people to leave
8 hospitals sooner who have TB and for them to seek
9 care in chest clinics where they should be getting
10 treatment instead of in our hospitals. These efforts
11 could save the city billions of dollars. Similar to
12 what we've been seeing lately, budget cuts in the
13 70's and 80's dismantled the public health response
14 to TB and led to a massive outbreak of drug resistant
15 TB in New York City that cost over $1 billion dollars
16 to control. We're in danger of repeating history and
17 we ask for your support to restore New York City's
18 funding to the health department's TB efforts and
19 save hospitals money. We're asking for $15 million
20 dollars in funding for TB, a $6.3 million dollar
21 increase over the current year. Thank you.
22 MS. CALHOUN: Good afternoon, my name is
23 Claudia Calhoun, I'm the Director of Health Policy at
24 the New York Immigration Coalition. I'd like to
25 start by thanking Chairwoman Carlina Rivera for your

2 long track record of working on health equity. We're
3 very excited about the creation of this committee and
4 we're very excited to work with you on public and
5 voluntary hospitals and how they serve immigrant
6 communities. We are an advocacy and policy umbrella
7 organization for more than 200 members across the
8 state and we work closely with H&H on extending
9 healthcare to immigrant communities. H&H is what I
10 really want to talk about today. The letter last
11 year right after the election, the open letter to
12 immigrants was a really important vehicle in
13 reassuring patients about the safety in the wake of
14 the change in the federal administration. So we
15 advocate to H&H, we advocate on behalf of H&H for
16 resources to benefit immigrant communities and we
17 advocate to H&H for ways that they can improve the
18 services that immigrants receive and listening to
19 President Katz's testimony is very heartening because
20 it's obvious and listening to the questions that were
21 asked here there's a lot of people that are concerned
22 about the same issues we're thinking of. One of the
23 things in the testimony that we submitted is a memo
24 that we wrote based on some focus groups that we did
25 in three different neighborhoods among Korean

2 speakers in Fleshing right at the end of 2016,
3 Spanish speakers on Staten Island, and French
4 speaking West Africans in East Harlem in the Bronx.
5 Even though these are very diverse communities, in
6 distinct parts of the city, there were numerous
7 cross-cutting themes that emerged about the
8 affordability of services, even sometimes when
9 there's a fee scale, lack of courtesy and a welcoming
10 attitude, and of course cultural competency and
11 humility, persistence of barriers in terms of
12 language access, waiting times, the difficulty of
13 making appointments by phone, and the importance of
14 access to primary, specialty, and behavioral
15 healthcare and I think it's important to note that
16 immigrant communities do understand that it's better
17 to go see a primary care doctor generally in our
18 experience and that going to the emergency room is
19 not the desirable way to get services. So some time
20 has passed since we convened these groups but we know
21 from our member organizations that many of these
22 issues persist. The other thing is that NYIC was a
23 participant in H&H's evaluation of its H&H options
24 program which was also at the end of 2016 and that
25 evaluation also turned up really persistent concerns

2 about language access, reducing the stigma of being
3 uninsured, and addressing what patients experienced
4 as a stigma associated with being an immigrant when
5 they seek healthcare services which was really
6 troubling. So the thing I want to talk about today
7 is very response to all of those challenges which is
8 the Action Health NYC pilot. This was a program that
9 H&H undertook in cooperation with a lot of other
10 partners to address many of the challenges. It was a
11 demonstration project that came out of the immigrant
12 health task force. I've got extensive comments on it
13 in my written testimony but we would love to see it
14 scaled up. Currently we don't know of plans to look,
15 there was a very rigorous evaluation that was done
16 and we don't know of plans to formally take those
17 learnings and incorporate them into care across the
18 system although of course, the comments that were
19 made today are very, especially about scaling up and
20 not focusing on pilots, were very heartening. So we
21 are very eager to work with the council and with H&H
22 on ways to do that. Thank you.
23 MS. BOWEN: Good afternoon Chair Rivera
24 and council staff or committee staff. My name is
25 Andrea Bowen and I'm a consultant working on behalf

2 of what we call the transgender and gender non-
3 conforming solutions coalition which includes anti-
4 violence project, Audrey Lord project, GMHC, the LGBT
5 community center, Make the Road, Sylvia Rivera Law
6 project, and the trans Latina network. These
7 organizations have been working in concert since 2015
8 to get policy and budget solutions from the community
9 and then bring that to policy makers. It was
10 basically kicked off by the LGBT caucus of city
11 council and the previous speaker who encouraged the
12 organizations to go into every borough and sort of
13 figure out what people needed. So the organizations
14 did that between 2016 and 2017 and we kind of took
15 those recommendations and have boiled them down right
16 now to six budget recommendations for this season.
17 We have brought these to the attention of mayoral
18 staff and agencies and basically we have the entire
19 list connected to our testimony if you want to see
20 it. In the event that these don't end up in the
21 executive budget we'd like to be able to work with
22 you in putting them in. Specifically, the proposal I
23 want to talk to you about today is TGNC is referred
24 to transgender and gender non-conforming people. A
25 TGNC healthcare liaison program that we've pitched to

2 H&H and DOHMH, it would be about $820,000.00 and so
3 the basic idea of it is this, even though health
4 insurance in New York City is increasingly covering
5 transgender healthcare needs, what we're finding from
6 the community is there's sort of a lack of
7 coordination of care. Everything from people getting
8 insurance denials still for care that should be
9 covered to arranging aftercare for people after
10 they've had certain surgeries. It also has to do
11 with just making sure you get respectful care for
12 stuff that isn't necessarily TGNC related. TGNC
13 people get diabetes, they have heart problems and
14 they need care for all of these things. We know
15 through some statistical information also that I site
16 in the testimony that TGNC people compared to their
17 non-TGNC, lesbian, gay, bisexual peers are at
18 significant disadvantages in health. So the pitched
19 liaison program, it would provide seven liaisons to
20 work in hospitals across the city to basically be
21 like case managers and advocates for TGNC patients
22 and force people rights within the system and make
23 sure that every part of the care team is in
24 communication. Again, this is an idea that came from
25 the community and now we're trying to push it as a

2 budget item. In the event that this doesn't end up
3 in the executive, again, we'll be asking for your
4 support in trying to make sure that this becomes a
5 reality and thank you for your time.
6 CHAIR RIVERA: Is there any position
7 close to this at any of the existing facilities do
8 you feel?
9 MS. BOWEN: So, H&H has an LGBTQ, I
10 forgot her exact title, it's LGBTQ liaison who does
11 amazing work coordinating care, making sure trainings
12 are happening, but for people who are more site
13 specific who can help people sort of traverse the
14 medical system and we have H&H in mind specifically
15 as having people who can be in different facilities
16 and help people with care in those facilities as
17 opposed to stretching this one person in many, many,
18 many different directions when she should really
19 probably be looking at the entire system as a whole.
20 So this would be people who help specific coordinated
21 individual care which is not really a position that
22 exists in the system to our understanding.
23 CHAIR RIVERA: Right. Okay, so there's
24 pretty much one person right now who's doing this
25 work?

2 MS. BOWEN: To my understanding, yes.

3 CHAIR RIVERA: Okay. No, I mean when
4 you're on site and you're interacting with people of
5 course it's very, very different than even a phone
6 call so thank you, thank you all so much for your
7 testimony. I want to go back to the tuberculosis and
8 the $15 million dollars that you're asking for, it
9 would go to what exactly?

10 MS. LESSAM: Ideally it would go to
11 staffing backup, the public health advisors who are
12 kind of the liaisons between the hospitals and the
13 outpatient care and enable that transition to happen.
14 It would go to community groups as well to be the
15 awareness raising and outreach arms on the ground.
16 We heard from a partner organization, African
17 Services Committee who signed onto our appeal for
18 funding which is also included in the written
19 testimony. They used to receive funding from the
20 health department and were able to offer free TB
21 screening and educational services and prevention
22 services in their community. They're no longer able
23 to do so because the health department's capacity for
24 funding such outreach is over now and they're having
25 to charge for tests now and a lot of their patients

2 can't afford that. So people are just going without
3 diagnosis and then they wind up ending up in
4 emergency rooms because they're coughing up blood
5 when we could have prevented active cases to begin
6 with if we found them earlier.
7 CHAIR RIVERA: And Ms. Calhoun thank you
8 for what you said about cultural competency and I
9 think that that's something that we all want to
10 experience whether it's language, whether it's your
11 background, whether it's your community. I know the
12 work that New York Immigration Coalition does and it
13 is very comprehensive. So I'm glad we're all feeling
14 good about the plans for H&H and of course we have a
15 lot of work to do. So I'm looking forward to reading
16 your testimony in depth and I really encourage you if
17 you have any questions specifically for me or of
18 course the fabulous staff here that really keeps me
19 going, please feel free to reach out. Thank you so
20 much. Okay and then our last panel is going to be
21 Jerry Wesley and Ralph Paladino and Kevin Collins.
22 Whenever you're ready Mr. Collins, you'll be first.
23 MR. COLLINS: How's that. Good
24 afternoon. Thanks for the opportunity to testify
25 today, I'm Kevin Collins the Executive Director of

2 Doctors Council SEIU and we represent doctors in H&H
3 and various city agencies including department of
4 health and Riker's Island. H&H takes care of all New
5 Yorker's and historically it takes care of the city's
6 poorest and sickest patients. It remains the city's
7 largest provider of healthcare to Medicaid patients
8 and faces of course, current financial challenges.
9 As we embark on this period of history, we're aware
10 of what we wrote in a white paper that we presented
11 to the city and H&H a while back. There is continued
12 pressures of course to cut costs, even as the ACA
13 expanded a number of patients who have health
14 insurance, H&H still takes care of a large number of
15 patients who do not have health insurance, especially
16 undocumented immigrants. Rather than be fearful or
17 reactive to this daunting reality, we have an ethical
18 responsibility to embrace this challenge. Cutting
19 services, consolidations, or closing hospitals is not
20 the answer. Privatization or outsourcing is not a
21 solution. These are misguided attempts at the
22 challenges facing us and abdicating our collective
23 mission to provide quality and affordable care to all
24 New Yorker's. Dr. Donald Burwick who's a former
25 administrator of CMS reminds us there is a choice to

2 be made. As he says, "Chop or improve." If we
3 permit chopping, I assure you that the chopping block
4 will get very full first with cuts to the most
5 voiceless and poorest amongst us but soon thereafter
6 to more and more of us. Fewer health insurance
7 benefits, declining access, more out of pocket
8 burdens, growing delays, if we don't improve the
9 cynics win. Doctor's council asks that you and our
10 professional members and our leaders will work with
11 H&H and its new CEO, Dr. Katz and take a strong
12 leadership role to improve our current delivery
13 system. We support the focus on clinical positions
14 and agree that H&H can grow itself out of the budget
15 situation by working together. We don't have to
16 shrink to succeed. Doctors are enthusiastic about
17 working together for the good of our patients. We
18 are pleased that H&H has plans to hire additional
19 physicians so there is more availability and shorter
20 wait times. Patients want our services and we need
21 to have the staff to be able to see them. We agree
22 with Dr. Katz that we need to invigorate and expand
23 primary care and improve access to specialty care and
24 implement plans to improve H&H's fiscal situation.
25 Specifically, we support focusing on clinical

2 positions instead of outside consultants in order to
3 reduce administrative expenses. We believe that the
4 system can successfully provide quality specialized
5 care that meets patients critical needs while
6 producing revenue. Importantly, H&H would greatly
7 benefit from recovering more revenue by improving
8 billing and coding practices and we look forward to
9 working together on that. In closing, we know that
10 we have to be thinking outside the box in terms of
11 trying to attract more patients into the system. We
12 suggest looking at a pilot program between the
13 department of mental health and a high needs
14 community, maybe we could run a project between the
15 school and an H&H facility. We support a number of
16 the increases in the CHS budget and we are always
17 cognizant of course of the convergence of two
18 factors; additional funding coming from Albany and
19 the state indigent care pool formula that we think
20 really needs to get fixed so H&H and other safety net
21 facilities throughout the state can get the money
22 that they're due for the patient population that
23 together we see. Thank you for the opportunity to
24 speak today.
25 CHAIR RIVERA: Thank you.

2 MR. PALADINO: Good day. I’m Ralph
3 Paladino, Second Vice President of Local 1549
4 District Council 37 representing 5,000 employees of
5 the public health system, New York City Health and
6 Hospitals. Our members perform financial and revenue
7 raising duties in H&H. I am an employee and a
8 patient at Belleview Hospital. I choose to be a
9 patient at Belleview Hospital. I could be a patient
10 any place else in the city but I choose to be at
11 Belleview because Belleview saved my life and has
12 improved my health. I don’t want to get into the
13 details, I’m abridging this as you can tell. The
14 problems at H&H stem around the issues around access.
15 There are two kinds of access; one access is primary
16 care doctors, clinics, etc. There’s no reason why I
17 should be waiting four months for primary care
18 appointments sorry. I’ve been waiting six months in
19 the past. It’s down to four. Metro Plus, signing up
20 our members, we represent Metro Plus signing up
21 people for healthcare. They’re waiting on the
22 average three months for primary care doctors for
23 their first visit and that’s why a lot of people who
24 sign up for Metro Plus do not stay in the system.
25 There’s a severe problem with access. The second

2 part of access is street access. Try calling some of
3 the hospitals and getting through to speak to someone
4 on the phone. Try calling to a clinic and try to
5 speak to someone in the clinic if you don't have a
6 direct number. Call centers, things have improved
7 some I have to say in the last year but call centers
8 also are hard to get through too although they're
9 better than they were. Much more has to be done with
10 that kind of access. We represent a lot of the
11 people in communications and the call center areas.
12 So that people will walk with their feet if they're
13 not able to get through on the phone and be able to
14 make their appointments. We're going right to the
15 local 1549 ask to the city council. First, to
16 actively engage the governor and state legislature to
17 ensure democratic decision making and fairness for
18 the public institutions in receiving the funding they
19 should be receiving. The New York State Legislature
20 should also have a say in who receives this emergency
21 fund and the methodology for payment. NYC H&H should
22 receive their fair share based on the proportion of
23 Medicaid and indigenous patients that we care for.
24 We don't now, we know this. There's a proposal to
25 upward to $1.5 billion dollars from one. We have no

2 problem with upping in from $1.5 billion dollars but
3 we do have a problem if the money is used that was
4 for the Blue Cross Blue Shield fiasco in the late
5 1990s. The money must go to patient care and it must
6 be fairly done and sent to where the patients, the
7 money should follow the patients. Uninsured and
8 Medicaid dollars need to be sent to those
9 institutions. To actively engage the governor and
10 state legislature to increase the reimbursement rates
11 for Medicaid, not raised in ten years and in
12 California, my understanding is and correct me if I'm
13 wrong Dr. Katz, that the cost of care, it's a law,
14 that the Medicaid reimbursement has to make the cost
15 of care. To increase the tax levy funding in New
16 York in the city. Currently 25% of H&H's budget is
17 tax levy money. Mayor DeBlasio needs to be
18 congratulated from upping it when Rudy Juliani was
19 the mayor it was down to practically nothing.
20 However, under the Dinkens Administration, in the
21 book, no one was turned away by Sandra Updike it's
22 documented, the city was up to 33% of H&H's budget.
23 So more could be done by the city. We also encourage
24 the use of seeking 1115 waivers from the federal
25 government because this administration, as bad as it

2 is in Washington, is believing in state's rights.
3 Our discussions with people in CMS and others, all
4 say that they are open to states doing things and
5 that should be looked into. To insist that New York
6 City H&H stop wasting tax dollars, paying higher paid
7 titles that they were not hired for and cease
8 circumventing the civil service system as currently
9 is going on in the institution. The documentation I
10 attached is only the tip of the iceberg. It's not
11 total numbers by the way those numbers equal a
12 million dollars, multiple that by the year. There's
13 more coming. To cease the continuation hiring of
14 private temporary workers to fill positions,
15 especially for clerical administrative duties. If
16 our work is unimportant, why do they have temps being
17 hired today, in the last couple of weeks going to
18 sessions for hiring? If our work is so unimportant
19 why and it's a quality of care issue. Last thing,
20 thank you very much for indulging me. To encourage
21 the New York City H&H in a genuine give and take
22 partnership with labor, with community advisory
23 boards, of which I was a member at one time, and
24 health and other parts of the advocacy community in
25 redesigning the work in the entire health delivery

system. We don’t need another DeLoitte. We don’t need another consultant who just recently took work away from our members. He was doing it for like 30 years and gave it to a higher title and they’ll have the consultant sit next to the person, not asking him questions and that doesn’t work. That stuff doesn’t work. So thank you very much. Again, I’m sorry to have run over.

CHAIR RIVERA: Thank you. That’s okay. Local 1549 you know if very special to me. My mother’s union.

MR. WESLEY: Thank you. Good afternoon Madame Chairwoman. Thank you for this opportunity to testify. I am Jerry Wesley, Healthcare Transformation Futurist at Satisfactology Business Systems. We specialize in satisfying customer care outcomes and healthifying workforce engagement and restoring organizational fiscal health. We’re satifactology is also one of the nations first patient satisfaction science of its kind. As a former senior management consultant of New York City H&H Corporation, I know firsthand that the workforce engagement and workforce development is drastically lacking. In preparing the workforce for the changing healthcare landscape

2 including social determinants of health. When I say
3 no one has adequately prepared the workforce, I mean
4 civil service, union leadership, city and state,
5 leadership for the city and state executives,
6 hospital executive leadership, nor the workers
7 themselves. Neither the universities. Non-
8 traditional training. No one has adequately prepared
9 our workforce and as a result they're kind of stuck.
10 So ACA, hospital care, ACA Hcaps, PCMH, and value
11 based payment models, they're all like apps that have
12 been downloaded onto the healthcare industries
13 desktop with no cultural operating system to run it.
14 So as a result, hospitals, including NYC H&H is
15 struggling with a workforce that is unprepared. So
16 with no cultural operating system to run them one of
17 the things that we would like to do is engage New
18 York Central H&H Corporation in shifting to what we
19 call in terms of thinking operational, cultural
20 operational thinking systems where we can begin to
21 prepare our workforce to be able to optimize value
22 based care experiences, outcomes, and payment models.
23 We're also interested in engaging NYC H&H Corporation
24 in a $500 million dollar cost reduction journey
25 towards healthifying organizational fiscal health.

2 We have over $87 million dollars spent on malpractice
3 costs, absenteeism costs and these aren't
4 projections, in terms of health risk factors, $67
5 million dollars. CMS denials, Hcaps, readmissions,
6 HAIs and a disengaged workforce were over $476
7 million dollars. So there is definitely and
8 obviously money and cost savings to be had we just
9 need a cultural operating system process to bring
10 that about. Thank you.
11 CHAIR RIVERA: Mr. Wesley, you're from
12 Satisfactology Business Systems?
13 MR. WESLEY: Right. I am from
14 Satisfactology Business Systems but we also have a
15 501(c)3, get healthy care together that we operate
16 out of Brooklyn and we're interested in working with
17 the city to retrofit NYC H&H Corporation workforce
18 and we'll be more than happy to submit a proposal in
19 terms of how we can do that in the most cost
20 effective way.
21 CHAIR RIVERA: And get healthy care is
22 based in Brooklyn?
23 MR. WESLEY: Yes. It's a 501(c)3 and the
24 reason why we set up our operations there even though
25 we're at One World Trade Center, one of the

2 executives said well how can we talk about
3 transforming health outcomes, 85 stories high. So
4 we've set up a presence in Brooklyn because Brooklyn
5 is home to the second worst health outcomes in the
6 state, the Bronx is the worst. So this is a serious
7 challenge for our healthcare system. Of the 34 one
8 star hospitals in New York State, eight of them is in
9 Brooklyn and most of NYC H&H are one star facilities.
10 Now the challenge is definitely there for us to bring
11 this about and one of the biggest issues is
12 addressing the workforce and I know it's a very
13 sensitive topic because they're not only New York
14 City employees, they also represent very powerful
15 unions who are a voting block that select the mayor
16 and city council. However, we have already had a
17 chance when I had a worked with NYC H&H Corporation
18 before, do a pilot of some of the ideas that we're
19 talking about now at Queens Hospital Center. This
20 was many years ago but we engaged the workforce,
21 created a very healthy environment, brought in the
22 unions, they supported the idea, this was the Hcaps
23 dry run exercise back in 2006, 2007 and Queens
24 Hospital which was one of the hospitals that the
25 former mayor Juliani wanted to close ended up having

2 the highest scores in the corporation. All of this
3 information I'm telling you. It was reported by Mr.
4 Villas in his end of the year report to the board of
5 directors. So we know how to bring this about. We
6 know how to make it happen. But what is required is
7 the wheel and so we have a union friendly model that
8 we use, called Charm Star which was very effective in
9 bringing about the top patient satisfaction scores,
10 doing the dry run as well as reducing malpractice
11 costs. We reduced over a two year period, over $20
12 million dollar malpractice cost reduction at Elmhurst
13 Hospital. This information is also available from
14 the New York City Controller's Office. So you can
15 validate everything I'm telling you.
16 CHAIR RIVERA: Well, thank you so much
17 and thank you Mr. Paladino. I know you mentioned
18 waiting four months for an appointment and I think
19 Dr. Katz was very intentional in saying that he is
20 going to continue working on the scheduling system,
21 also customer service. He even mentioned picking up
22 that phone that you mentioned that never got answered
23 when you called. The local ecosystem here. And
24 Kevin, of course thank you for your focus on clinical
25 positions. I think that was also made clear in the

doctor's testimony. So I just want to thank you all for your testimony today, for waiting, for your patience of course, and for attending this hearing. Are there any other members of the public that wish to testify today? Seeing none, this hearing is adjourned. Thank you so much everyone.

<u>C E R T I F I C A T E</u>

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

Date <INSERT TRANSCRIPTION DATE>