CITY COUNCIL
CITY OF NEW YORK

------------------------ X

TRANSCRIPT OF THE MINUTES

Of the

COMMITTEE ON HOSPITALS JOINTLY WITH

COMMITTEE ON MENTAL HEALTH, DISABILITIES AND

ADDICTION

------------------------ X

June 20, 2018
Start: 1:12 p.m.
Recess: 3:24 p.m.

HELD AT: NYC Health + Hospitals/Metropolitan
6th Floor Auditorium Main Building
1901 First Avenue
New York, NY 10029

B E F O R E: CARLINA RIVERA
Chairperson

DIANA AYALA
Chairperson

COUNCIL MEMBERS:
Alicka Ampry-Samuel
Fernando Cabrera
Robert F. Holden
Mark Levine
Francisco P. Moya
Keith Powers
Antonio Reynoso
James G. Van Bramer

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

Charles Barron, M.D.
Deputy Chief Medical Officer
New York City Health & Hospitals

Elizabeth Ford, M.D.
Correctional Health
New York City Health & Hospitals

Judith Cutcheon
Registered Nurse
Woodhull Hospital

Ann Bovay
Retired Registered Nurse

Jeanine Thomas, Representative
District Council 37

Jennifer Rento Kentun
Registered Nurse
Metropolitan Hospital

Leonard Davidman
Psychologist
Metropolitan Hospital

2 CHAIRPERSON AYALA: [gavel] Good
3 afternoon, we're calling this meeting to order. So
4 good afternoon, I am Council Member Diana Ayala,
5 Chair of the Committee on Mental Health, Disabilities
6 and Addiction. I would like to thank you for
7 attending and making time for us this afternoon.
8 This hearing will focus on the steps that the City is
9 taking to ensure that New Yorkers from all walks of
10 life have equitable access to psychiatric care in our
11 hospitals in the future. This issue has special
12 resonance for me because the situation in my
13 community is so challenging. Statistics from the
14 OHMH told that East Harlem has the highest rate of
15 psychiatric hospitalizations of any neighborhood in
16 the city. Let that settle in and suicide is the
17 second leading cause of death among Latino
18 adolescence according to the New York State Office of
19 Mental Health. In recent years Health and Hospitals
20 has seen a 20% increase in hospitalizations of
21 patients with mental illness and public hospitals
22 designate a greater share of their beds for
23 psychiatric services than voluntary hospitals do. As
24 we examine the ways in which our city can move
25 forward to a more sustainable distribution of care,

2 it is important to note that ThriveNYC, the Mayor's
3 $800 million mental health initiative will have a
4 significant role to play. We hope to achieve a
5 greater understanding of the ways in which the public
6 hospital system is coordinated with agencies to
7 provide services and to identify areas where funding
8 can best meet all these needs. I am excited to hear
9 from experts in medicine, behavioral health and
10 public policy and I am confident that we will make
11 strides today in building a better system. In
12 closing, I would like to thank Metropolitan Hospital
13 for hosting us as they have played an instrumental
14 role in providing mental health services to East
15 Harlem residents. I would also like to thank
16 committee staff counsel, Silvester Ervana [phonetic],
17 policy analyst, Michael Cerst [phonetic], finance
18 analyst, Jeanette Merrill and my legislative
19 director, Bianca Amadina [phonetic] for making this
20 hearing possible. Finally, I would also like to
21 recognize Council Members that have joined us,
22 Council Members Fernando Cabrera, Alicka Samuel,
23 Carlina Rivera, Jimmy Van Bramer, and Council Member
24 Holden. It's all yours.
25

2 CHAIRPERSON RIVERA: Thank you, Diana.
3 Good afternoon everyone. I am Council Member Carlina
4 Rivera, Chair of the Hospitals Committee. Today the
5 Committee is holding a hearing to examine the future
6 of psychiatric care in New York City's hospitals and
7 of course I would like to start off by thanking
8 Metropolitan Hospital for hosting us here today and
9 want to congratulate Metropolitan and all of the
10 hospital staff, doctors, nurses, administrations,
11 facilities staff, everyone for recently an A grade
12 for hospital safety from a national patient safety
13 watchdog.
14 [applause]
15 CHAIRPERSON RIVERA: Health & Hospitals
16 is responsible for 43% of all inpatient care for
17 mental health in New York City. This crucial work is
18 being conducted against the backdrop of future
19 federal and state cuts to funding that helps cover
20 the cost of caring for the uninsured, known as
21 disproportionate share of hospital funding or DISH
22 funding. This, the majority of H & H's DISH funding
23 comes from what remains after the state distributes
24 fixed funding amounts to all hospitals including
25 voluntary hospitals. As DISH funding is cut, little

2 will be left over for H & H. Meanwhile, nearly one
3 million city residents remain uninsured and our
4 public hospital system treats a large proportion of
5 these individuals and yet in the midst of this
6 tightening fiscal context, it appears that H & H's
7 role as a primary provider of inpatient care for
8 mental health in New York City is set to increase in
9 the years ahead. According to a report released by
10 the Independent Budget Office IBO, in July of 2017,
11 mental health hospitalization at the eleven hospitals
12 that comprise H & H grew from 20,550 in 2009 to
13 24,705 in 2014 which is an increase of roughly 20%.
14 Over the same six year period, mental health
15 hospitalizations decreased by approximately 5% among
16 the voluntary hospitals in New York City. Mental
17 health hospitalizations comprised just 3.5% of all
18 hospitalizations in private hospitals compared to
19 12.9% at H & H. The Committee looks forward to
20 hearing about the strategies H & H is pursuing to
21 cope with increasing demands of inpatient mental
22 health services and how H & H is preparing to provide
23 an even greater share of inpatient mental health
24 services in the city in the context of ongoing
25 physical constraints and the loss of psychiatric

treatment beds in volunteer hospitals. The Committee would also like to examine the role of voluntary hospitals in addressing these critical concerns. Tackling this difficult problem is crucial to maintaining the viability of our great public hospital system. I want to thank everyone here for making it to El Barrio today and very, very special thanks to Council Member Ayala for hosting us in her home hospital and for all the work that she has done around mental health and behavioral health and of course to all the staff here for your accommodations. I know that we are guests and we want you to know that you have friends in City Hall who really want to support your work. I think being here in this hospital has always been something that I've talked about in every single one of my hearings or interviews because I think bringing visibility is so, so important to our public health system. These facilities, these eleven hospitals throughout our city all look different. They're all vibrant, they're all busy and I think that bringing these hearings here is important to show the faces of the people doing the work and the faces of the patients that we need to take care of so I want to thank

2 everyone for being here and of course to my fellow
3 colleagues at the City Council and now we will be
4 taking testimony and I want to acknowledge Council
5 Member Mark Levine. So hello, thanks for being here
6 so we're gonna administer the oath. Do you affirm to
7 tell the truth, the whole truth and nothing but the
8 truth in your testimony before this Committee and to
9 respond honestly to Council Member questions?
10 DR. BARRON: Yes, I do.
11 CHAIRPERSON RIVERA: Okay, you may begin.
12 DR. BARRON: So good afternoon,
13 Chairperson Rivera and Chairperson Ayala and members
14 of the Committee on Hospitals Systems and the
15 Committee on Mental Health, Disabilities and
16 Addiction. I am Dr. Charles Barron. I'm the Deputy
17 Chief Medical Officer for New York City Health &
18 Hospitals and I thank you for the opportunity to
19 testify before you on the future of psychiatric care
20 in New York City's hospital infrastructure. Health &
21 Hospitals is the main provider of behavioral health
22 and inpatient psychiatric care services in New York
23 City with nearly 1,500 licensed psychiatric beds
24 representing 48% of all psychiatric inpatient beds in
25 the metropolitan area. As such, we provide a

2 significant portion of behavioral health inpatient
3 services in New York City which underscores the need
4 for continuous stability in the public hospital
5 system. Over the last several years, health care
6 delivery in New York State has been undergoing a
7 transformation, a shift in providing care in the
8 inpatient setting to community based care. In April
9 2014, the Federal Centers for Medicare and Medicaid
10 services or CMS approved New York State's Medicaid
11 waiver request in the amount of $8 billion over five
12 years. The goal of the delivery system reform
13 incentive payment or DSRIP program was to achieve a
14 25% reduction in avoidable hospitalizations for
15 Medicaid patients including psychiatric
16 hospitalization and restructure the health care
17 delivery systems. To that end from 2014 to 2017,
18 Health & Hospitals has seen a decrease in our all
19 cause and psychiatric readmission rates by 24 and 27%
20 respectfully. In keeping with the hospital
21 industry's shift from inpatient to ambulatory care at
22 Health & Hospitals, we are in the process of
23 deploying a system wide and multi-phase expansion of
24 ambulatory health care which we expect to complete by
25 2020. New York City Hospital Metropolitan will serve

2 as a demonstration site and a center for innovation
3 bringing together the most innovative care models and
4 community driven strategies. Additional and
5 complimentary initiatives will also include
6 collaboration with community based providers focusing
7 on depression, substance misuse, unstable psychosis
8 in neighborhoods especially impacted by behavioral
9 health programs. Also, strategies to improve safety
10 for our patients, intensive outpatient programs which
11 allow increased frequency and customized treatment to
12 meet the patient's needs and the use of
13 telepsychiatry to assist with workforce shortages and
14 provide increased access for patients. Our acute
15 care behavioral health services include seven adult
16 and one child and adolescent comprehensive
17 psychiatric emergency programs or CPAP's which
18 include psychiatric emergency rooms, extended
19 observation beds, mobile crisis intervention services
20 and access to crisis beds. Last year there were more
21 than 63,000 adult and 8,000 child and adolescent
22 visits to Health & Hospital's psychiatric emergency
23 rooms. Our inpatient services provide individual
24 therapeutic care to stabilize mental illness
25 episodes, promote rehabilitation and recovery and

2 return to the community in less restrictive
3 modalities and care. As previously acknowledged,
4 while inpatient care will also be needed especially
5 for those with serious and persistent mental illness,
6 acute psychosis or are at risk for suicide, we agree
7 with the imperative to keep patients out of the
8 hospital if they don't need to be there. Health &
9 Hospitals provides a comprehensive array of
10 ambulatory behavioral health care. These include
11 mobile crisis teams, outpatient clinics, day
12 treatment programs, partial hospital programs and
13 case management mental health programs. For those
14 patients who require significant levels of support,
15 our facilities also operate assertive community
16 treatment teams or ACT teams. These ACT teams
17 programs function as clinics without walls treating
18 individuals in their homes or in the community. Of
19 the 38 ACT teams in New York City, Health & Hospitals
20 operates 12 of these teams. Children and adolescents
21 receive services through developmental evaluation
22 clinics, family support programs, adolescent
23 treatment programs, school based programs and
24 outpatient clinics. Harmful substance abuse is a
25 significant population health problem in New York

2 City and among Health & Hospital's patients. There
3 are approximately 90,000 unique patients with
4 substance abuse disorders at Health & Hospitals every
5 year. Approximately 20% of primary care patients are
6 at moderate risk of harmful substance abuse or SUB.
7 Of the patients with substance abuse disorders, close
8 to 15% have a primary diagnosis of opioid use
9 disorder, and 45% have a primary diagnosis of alcohol
10 abuse disorder. Health & Hospital's facilities
11 provide an extensive array of substance abuse
12 disorder services. Inpatient detoxification is
13 provided at seven facilities and we have thirteen
14 outpatient counseling programs, four Methadone
15 treatment programs, two half-way houses and a number
16 of specialized services for families, adolescents,
17 and women. In 2017, the Mayor and First Lady
18 announced HealingNYC, a comprehensive effort to
19 reduce opioid overdose by 35% over the next five
20 years. Health & Hospitals is a key partner in this
21 initiative reinforcing our commitment to transform
22 into a system of excellence for opioid services. We
23 are grateful to the city for providing nearly $5
24 million in funding to date which has allowed us to
25 implement several initiatives including first,

2 hospital based opioid overdose prevention programs.
3 Seventeen of our patient care sites are now state
4 certified opioid overdose prevention programs that
5 routinely dispense Naloxone based on best practices
6 including overdose prevention training of patients
7 and community members. This unified strategy for
8 Naloxone distribution will enable Health & Hospitals
9 to capture system wide data to target future overdose
10 prevention work. Second, we've established
11 consultation for addiction treatment and care in
12 hospital teams or as we call them CATCH teams. To
13 maximize patient connection to substance abuse care,
14 in the fall Health & Hospitals will initially launch
15 CATCH at four hospitals, Bellevue, Metropolitan,
16 Lincoln, and Coney Island soon followed by Elmhurst
17 and Woodhull in 2019. We will specifically recruit
18 staff to form interdisciplinary teams that will
19 engage patients with substance abuse disorders who
20 are in the hospital for any condition. The program's
21 target is to reach out and deliver treatment to more
22 than 8,000 patients with opioid abuse disorder per
23 year across the six hospitals. Third, buprenorphine
24 expansion in primary care. In order to treat as many
25 possible patients with opioid abuse disorder across

2 our system, Health & Hospitals is expanding
3 medication for addiction treatment in primary care
4 clinics. By 2020, we will have increased the number
5 of providers to 450 who are certified to prescribe
6 buprenorphine. Through our efforts, the number of
7 patients who receive medication treatment in our
8 system will increase to 2,500 over the next three
9 years. Integrating primary care with behavioral
10 health and substance abuse treatment in this way will
11 increase access to treatment and enable primary care
12 providers to better serve the patient population.
13 Fourth, we've established emergency department peer
14 advocates addressing substance use. Leveraging an
15 initiative launched by the New York Alliance for
16 Careers in Health Care and the City University of New
17 York at Queensborough Community College which trains
18 and certifies peer advocates. Health & Hospitals
19 created an integrated substance abuse disorder in
20 care management and peer counselor program in three
21 of its emergency departments with the highest volume
22 of substance abuse patients, Harlem, Metropolitan and
23 Woodhull. Using a relational care model, peer
24 advocates engage with patients coming to the
25 emergency department and connect them to appropriate

2 ongoing addiction care. This program will be rolled
3 out to the remaining eight emergency departments in
4 the next year. Finally, in this program there is
5 judicious prescribing training and guidance. To
6 ensure that all possible prevention strategies are
7 implemented, a total of 2,220 providers across Health
8 & Hospitals received educational and training in
9 judicious opioid prescribing in 2017. Judicious
10 subscribing means prescribing smaller doses of opioid
11 analgesics for shorter duration and avoiding co-
12 prescriptions of benzodiazepines which can increase
13 the patient's risk of overdose. Additionally,
14 prescribers will receive reminders through Health &
15 Hospitals electronic health record system to ensure
16 fidelity to these prescribing guidelines. In 2015,
17 the Mayor and First Lady announced ThriveNYC, a plan
18 of action to guide New York City to effectively and
19 holistically support the mental health of its
20 residents. With over $3 million in funding to date,
21 Health & Hospitals has implemented a number of
22 programs within the Thrive initiatives. First,
23 universal maternal depression screening. As part of
24 the Thrive initiatives, all prenatal and postpartum
25 patients seen at Health & Hospitals are screened for

2 depression. Mothers are screened in both the OB/GYN
3 and Pediatric clinics during the well-baby visits.
4 Anyone screening positive for possible depression is
5 then connected to ongoing mental health care. As
6 part of this work, Health & Hospitals participates in
7 the city's maternal depression collaborative run by
8 the Greater New York Hospital Association and the New
9 York City Department of Health and Mental Hygiene.
10 Second, we participate in the New York City mental
11 health cores. Thirty mental health service core
12 members, all recently graduated Masters and Doctoral
13 level clinicians, work in substance abuse programs,
14 mental health clinics and primary care practices
15 within Health & Hospitals. When fully staffed, the
16 core throughout the City will provide approximately
17 400,000 additional hours of service in communities
18 where they are needed most including in primary care
19 settings which is where most New Yorkers receive
20 their regular medical care. Third, the mental health
21 services in all family justice centers. Health &
22 Hospitals expanded on-site mental health services at
23 all five of the city's family justice centers which
24 last year served more than 37,000 domestic violence
25 survivors. The staff provide direct care and also

2 offer mental health support, skill building
3 opportunities and mentoring to other family justice
4 center staff. This new program will enable to
5 accommodate 1,000 clients per year and fourth, the
6 mental health first aid. This groundbreaking public
7 education program teaches the skill needed to
8 identify, understand and respond to signs of mental
9 health substance abuse challenges and crisis. Thus
10 far, 826 Health & Hospitals employees have been
11 trained and certified. The course gives people the
12 skills to help someone who is developing a mental
13 health problem or experiencing a mental health crisis
14 and help guide them to treatment programs. The
15 evidence behind the program demonstrates that
16 individuals who have completed the mental health
17 first aid training have a greater confidence in
18 providing help to others, a likelihood of advising
19 people to seek professional help and improve
20 concordance with helping professionals about
21 treatment and a decrease in stigmatization attitude.
22 Health & Hospitals as the largest provider of care to
23 individuals with mental illness and substance abuse
24 disorder in New York City faces many challenges to
25 providing high quality patient centered care. These

2 challenges which are not unique to us include
3 eliminating the stigma and discrimination associated
4 with seeking care for the treatment of mental health
5 and substance abuse disorders, a patient population
6 that is frequently resistant to treatment and often
7 interfaces with the criminal justice system,
8 significant numbers of uninsured individuals who lack
9 resources to pay for their treatment and medication,
10 an inadequate reimbursement for services. Health &
11 Hospitals cannot resolve these challenges alone and
12 will continue to partner with government and key
13 stakeholders to forge solutions and I'll be happy to
14 answer questions that you may have at this time.
15 CHAIRPERSON RIVERA: Thank you so much.
16 Thank you for listing some of the programs that you
17 are working on in interagency and, of course, Health
18 & Hospitals what you're trying to provide for every
19 New Yorker. So we have a few questions for you. I
20 know there's some people here also from Health &
21 Hospitals that may assist you in answering questions.
22 Okay, great so you spoke, especially at the tail end
23 of your testimony about social determinants and
24 stigma and I want to ask about intersectionality
25 between social determinants and mental health and so

how does the intersection between mental health and other social determinants impact a person's likelihood to need inpatient care. So if their experience is receiving care and they're discharge planning and I just want to also ask, has there been an increase in need for a particular community when it comes to this such as young adults or those experiencing homelessness or those who are incarcerated?

DR. BARRON: So certainly I think that many of the social determinates help and those specifically that you mentioned such as homelessness seriously impact the ability of someone to be in treatment and to remain in treatment. It's very hard if you're homeless and seeking your primary basic needs to be met oftentimes to go to treatment and be in treatment for mental health services so I think that that group particularly has a difficult time complying with mental health treatment. I think that's why that we've been developing so many of the other services such as our mobile treatment, the ACT teams, our mobile crisis teams and we're looking to develop further teams that will be providing ongoing treatment in the community where it would be easier

2 for people that are homeless and have other issues
3 and problems to seek treatment. Certainly the issues
4 of involvement with the criminal justice center
5 system also complicate more treatment but fortunately
6 there have been additional treatment resources that
7 are also being provided to that particular group too.
8 CHAIRPERSON RIVERA: So how are your
9 facilities accessing and then providing services for
10 these particular needs?
11 DR. BARRON: Our facilities as well as
12 the system in general collects a lot of information
13 and data related to certainly to homelessness, to
14 mental illness, the diagnosis and the needs of
15 patients and their discharge plans, and where they're
16 going and where the gaps look at.
17 CHAIRPERSON RIVERA: What do you think
18 could be done better to meet the needs of the
19 patients who require support in addition to the
20 behavioral health service in terms of looking at it
21 comprehensively and holistically?
22 DR. BARRON: Well certainly I think that
23 one of the biggest areas that the mental health
24 system is facing at this point of time has to do with
25 our homeless population and I think that there are

2 certainly a number of efforts that are being put
3 forth for the homeless, a lot of projects. I
4 certainly thank an increase in affordable housing for
5 mental illness and substance abusing mentally ill
6 patients would be a tremendous help, to be able to
7 get them into stable housing. I think there are
8 other programs being developed in the sense of
9 looking at how to provide better mental health
10 services in areas where they are sometimes in the
11 shelters, sometimes on the street but I think that
12 that's one of the areas that really I think is a big
13 focus is affordable housing.
14 CHAIRPERSON RIVERA: Are there any
15 updates on the developing of additional long-term
16 mental health care facilities in the city whether
17 they're a part of the eleven acute care system or
18 whether they're smaller, a part of the Gotham Health
19 Center network? Is there any, are you looking to
20 increase behavioral health capacity and service?
21 DR. BARRON: Actually yes, one of our big
22 focuses is to increase access and capacity of our
23 mental health services and substance abuse disorder
24 services. That's one of the reasons for the shift
25 toward ambulatory care that we've seen have been

successful. There certainly will always be a need for some inpatient beds that we will need for acute crises, etc. but if we were able to engage our patients into appropriate level services in the ambulatory care area where there is a longer term stability and better mental health, that would be better. We are certainly looking at developing different types of services that provide more needs, more community based services. We're putting in intensive outpatient programs, IOP's we call them, that will increase access and allow patients to actually attend clinics multiple times a week, sometimes having several services in one day which makes it more convenient for them to attend and get, you know, perhaps seeing the doctor, getting medications, for therapy, attending a group all within the same day. We are looking at also expanding, in a sense some of our, how we do some of our inpatient treatment. There are certain special needs patients that may need longer term care so we're looking at how we may be able to provide that while maybe they're being hooked up with appropriate housing.

2 CHAIRPERSON RIVERA: So are the wait
3 times long for, you know, an appointment with H & H?
4 What are the current wait times for a psychiatric
5 visit at one of your facilities now and do you expect
6 with the look to increase capacity, that they'll be
7 shorter?

8 DR. BARRON: Our current average wait
9 time, we usually measure by what's called the third
10 next available appointment. It's a standard measure
11 of that. Our current third next available
12 appointment to date is between four to six days.
13 However, we have developed capacity within our
14 clinics and our programs that if someone has a urgent
15 need for that, we can give them same day
16 appointments. We are continuing to address the
17 access issues and actually moving down to hopefully
18 to one and two days and we've moving forward to that.

19 CHAIRPERSON RIVERA: Okay, I have a few
20 more questions but I'm gonna turn it over to my
21 colleagues and first I'll go to Chair Ayala.

22 CHAIRPERSON AYALA: Is the outpatient
23 wait one or two days, is that for outpatient or one
24 or two days waiting period?
25

2 DR. BARRON: That is our goal ultimately
3 for all of our ambulatory care facilities.
4 CHAIRPERSON AYALA: That is your goal.
5 DR. BARRON: Some of them are there one
6 or two days. Some of them are three or four days but
7 our average is around three to four days but as I
8 said, if someone is in need of an urgent appointment,
9 our facilities are able to give someone a same day or
10 next day appointment for that, yes.
11 CHAIRPERSON AYALA: Can you explain the
12 thought process behind providing more ambulatory care
13 as opposed to inpatient for psychiatry because I, you
14 know, as the sibling of a person with mental illness
15 and I struggled with the system for quite some time
16 and my brother was hospitalized several times and I
17 felt almost like I had to literally fight to get him
18 admitted because when I brought him in, the system
19 said he was presenting and I use a quotation mark
20 "the symptoms that he wanted to present at the
21 moment". They did not seem like symptoms that would
22 create a situation where he was harmful to himself or
23 to the public when I knew different because as a
24 person that was observing, you know, specific
25 behavior that was dangerous in nature so my concern

2 is that patients will come into emergency sites and
3 they will be evaluated but because they're not
4 presenting at the moment, that they will be
5 discharged with an appointment to come back to
6 ambulatory care. Is there a follow-up, you know, to
7 that? What happens if the person doesn't show up? I
8 have a couple questions so if you can kinda walk me
9 through that process.
10 DR. BARRON: Sure, certainly, you know,
11 it's a very traumatic time when anyone with a mental
12 illness needs, goes into an acute stage, is a
13 traumatic time for that person, the patient
14 themselves and it's a traumatic time for family
15 members that have to support them in trying to do the
16 best thing that they can so it's a very difficult
17 process. I certainly understand some of your
18 difficulties that you've gone through. We certainly
19 have a process where we try to make the best
20 assessment when someone comes into whether it's the
21 Emergency Room or to a Urgent Clinic or clinic visit
22 presenting with potentially acute symptoms or
23 behaviors. We do as comprehensive and as full
24 assessment as we possibly can using all the
25 information that we can gather, certainly from the

2 patient themselves and the physicians, the
3 psychiatrists, certainly are able to do, you know,
4 the mental status examination of the patient, review
5 history, etc. We make every effort to, with any
6 patient, to include information from families, from
7 people who are their support system, live with them,
8 know them, know their behaviors, other treatment
9 providers if they are not in our system because we
10 really want to make the best decision. Our goal is
11 to provide the best care. Our goal is to be
12 responsive to the people that come to serve, to us
13 for service, to do the best jobs we can. Sometimes
14 we may miss something. Sometimes because of
15 confidentiality laws with the state and federal and
16 the refusal of the patient to allow us to speak to a
17 treatment provider or family members, we may have
18 some limited knowledge but we certainly try to use
19 every bit of knowledge we can to make the right
20 decision as to where a person should be. Are they
21 appropriate for an outpatient treatment and now that
22 we're developing more intensive outpatient treatments
23 such as the intensive outpatient program and our
24 partial hospital programs, sometimes people can be
25 managed appropriately in the community, in their

2 homes with intensive outpatient services where they
3 may come daily for a period of time until they are
4 more stable. If we find that it's appropriate for
5 them to be an inpatient then we would take
6 appropriate steps hopefully with the voluntary
7 cooperation of the patient for that. We make every
8 effort to make a appropriate and safe discharge for
9 that patient. We want to make sure they have been
10 stabilized and are ready to return to the community
11 and to an appropriate level of care. We use often
12 times our partial hospitals and our intensive
13 outpatient programs as step downs from the inpatient
14 service because we realize that sometimes going from
15 a more barely acute patient setting to a traditional
16 outpatient clinic may be too big of a jump for the
17 person to make so we do have these other treatment
18 programs that are able to provide an intermediate and
19 a step down type of treatment.
20 CHAIRPERSON AYALA: Again, my concern is
21 when you are giving appointments and people don't
22 show up. So you give an appointment and like I don't
23 want to go because I believe that the medicine you're
24 giving me is poisoning my body and it's not in the
25 best interests of my body to ingest it so I'm not

going to go to the hospital and then a few weeks later the person is readmitted with presenting symptoms. What happens then?

DR. BARRON: So I think that some of the services that we have been starting to put in place and put in place I mean that has been one of the dilemmas that the mental health system both Health & Hospitals and anyone else has faced in the sense that it's oftentimes challenging for the patients that use our services with mental illnesses or substance abuse disorders to have full insight into some of their problems and what's going on. As you mentioned, sometimes they feel the medication is wrong or poison or something of that nature. What we have been doing is we reach out to the person. We have follow-up workers who actually contact them to see if they've made an appointment. They contact the patient themselves, reminding them of the appointment and to check to see if they've made the appointment. If for some reason they're not making the appointment, we try to make another appointment and engage them. At times we need to, we will refer the appointment, if they're not making the appointment to one of our mobile crisis teams to go out and assess the person

2 in their environment, in their home to see if they
3 can help stabilize the person more and engage them
4 and keep them that. We're also instituting the use
5 of peers or consumers that are now trained in peer
6 advocacy. We find that this is a very successful
7 means of trying to help patients and mental illness
8 and substance abuse disorders to engage in treatment.
9 Certainly, it's very important that you go to
10 treatment, that you take your medication, that you
11 follow the treatment plan and so we are really
12 rolling out a lot of peer advocates because it seems
13 to have been very successful in helping people make
14 that transition into ambulatory care and actually to
15 engage and go to treatment, to take their medication
16 so we are really focused on making every effort we
17 can in trying to help the person engage in
18 appropriate an appropriate level of treatment.
19 CHAIRPERSON AYALA: Can you tell us what
20 is the capacity of beds in H & H hospitals right now
21 for psychiatric care beds?
22 DR. BARRON: We have a total of 1,499
23 beds.
24 CHAIRPERSON AYALA: 1,400 and are they
25 underutilized?

DR. BARRON: No, they're utilized.

CHAIRPERSON AYALA: No, they're all utilized.

DR. BARRON: We're, yes. I mean we're, our average occupancy rate is around, which varies from day to day, month to month, is around 90%.

CHAIRPERSON AYALA: What is the length of time that a patient is usually in the hospital?

DR. BARRON: Our current average length of stay is 18 days.

CHAIRPERSON AYALA: 18 days.

DR. BARRON: Yes, that's the average.

CHAIRPERSON AYALA: Are any of those hospitalizations a result of Kendra's law?

DR. BARRON: I'm sorry, pardon.

CHAIRPERSON AYALA: Are any of those hospitalizations in any way related to Kendra's law?

DR. BARRON: They certainly potentially are. If someone is considered to be dangerous and sometimes because of the Kendra's law they are brought to our emergency rooms and we access them to be dangerous or with acute symptoms, then they would be hospitalized, yes.

2 CHAIRPERSON AYALA: Do you have any data
3 that suggests how many patients have been admitted
4 because of that law?
5 DR. BARRON: I don't have that data with
6 me right now but I can certainly get back to you with
7 that information.
8 CHAIRPERSON AYALA: I would appreciate it
9 and my final question before I let my colleagues, in
10 terms of homeless outreach a lot of money is being
11 allocated to outreach, how does, what does mental
12 health look like when you're living under a bridge?
13 DR. BARRON: That's, as I sort of
14 mentioned before, that's one of the huge challenges I
15 think. It's very difficult for someone who is
16 homeless and mentally ill to be part of appropriate
17 treatment. When you're looking for where you want to
18 live, where you want to stay out of the elements,
19 where you're gonna find some food, where you're
20 finding shelter, it's very difficult so that's why we
21 really begun to work with the Department of Homeless
22 Services, with a lot of the community based homeless
23 agencies and partnering with them to try to deliver
24 care where the person is and to try to begin to work
25 with them towards getting in a better situation in

2 some affordable housing. A lot of our efforts are
3 focused with our patients who are homeless and trying
4 to get them into housing.
5 CHAIRPERSON AYALA: Actually I'm sorry
6 colleagues, I lied. I have one more question.
7 DR. BARRON: Sure.
8 CHAIRPERSON AYALA: Last, two weeks ago
9 we had a young woman, an 11 year old child, jump off
10 the roof in one of our public housing developments
11 and committed suicide. Apparently there was a pact
12 in the school and many of the children had been
13 watching a specific show on Netflix that followed the
14 life of a young woman in high school that had
15 committed suicide. What are we doing in terms of
16 adolescent mental health services at Metropolitan
17 Hospital or in all of the H & H hospitals I'm not
18 very familiar with the type of service and how do we
19 distinguish the services between adults and children?
20 DR. BARRON: Well, I think one of the
21 problems, suicide is certainly a very significant,
22 worrisome and difficult problem and as the acute care
23 providers for people who may be contemplating
24 suicide, we certainly take that very seriously and we
25 provide anyone that walks in or comes in any way to

2 any one of our portals of entry whether it be the
3 Emergency Room, the clinics, at our inpatient
4 service, everywhere, we really do a comprehensive
5 assessment using evidence based tools for suicide
6 assessment and risk assessment to really determine
7 what is the risk of suicide for that person so we can
8 provide the best level of care. People that are
9 considered at risk for suicide, we provide with
10 safety plans, work with them on developing safety
11 plans with them and their support system, their
12 families. In our adolescent units particularly, we
13 focus a lot on suicide and education, about mental
14 illness, about depression, about suicide. We work in
15 our school based programs and wherever we treat the
16 adolescents really with a lot of places to provide
17 not only the treatment but in a sense of the
18 education of them about the potential hazards in
19 thinking about suicide and what reality suicide is.
20 CHAIRPERSON AYALA: Is that part of the
21 primary care assessment so if the child is coming in
22 with the parents, are you having this discussion and
23 making this information available to them?
24 DR. BARRON: Yes, even in primary care or
25 pediatrics, absolutely we are assessing through our

collaborative care programs for evidence of depression and especially for suicide risk.

CHAIRPERSON AYALA: Thank you.

CHAIRPERSON RIVERA: We want to acknowledge we've been joined by Council Member Moya and we want to get to some of the questions of our colleagues so we are going to start with Council Member Mark Levine.

COUNCIL MEMBER LEVINE: Thank you to both of our Chairs for holding the hearing on such an important topic and we're just so lucky to have both of you in these important leadership roles and these two vital committees. I want to acknowledge just how much H & H is doing in behavioral health. You said you have 48% of behavioral health beds city wide. I think in terms of services provided, maybe patient visits, it's over 50% and I could be wrong about that which means in other words you are providing more behavioral health services in this city than every other institution combined and that's partly because to be blunt, just not a lot of money to be made in behavioral health and you're doing it because the city needs you to do it. We just want you to know how grateful we are for that. If you stopped doing

2 that service, it would be disastrous for the health
3 of the city and I do think that therefore the city
4 government should be supporting you with funding and
5 I don't think we do much of that. Do you know how
6 much direct city money comes in to your operation,
7 behavioral services system wide?
8 DR. BARRON: I do not know the total
9 amount. I know certain particular programs
10 themselves but I don't know but I can get you that
11 information and definitely will.
12 COUNCIL MEMBER LEVINE: I'm told out of
13 the Thrive initiative which is $800 million all
14 totaled, $10 million of that is coming into H & H.
15 Does that sound right?
16 DR. BARRON: Yes, that's right for
17 Thrive, yes.
18 COUNCIL MEMBER LEVINE: I'm not looking
19 to divert money from any other great H & H priorities
20 but I gotta say, that doesn't say like a lot
21 considering the scale of the work that you are doing
22 and so I would certainly be an advocate working with
23 our Chairs to look at how the city could inject money
24 into work that would up the quality of care whether
25 it's in staffing or other services that would impact

2 the patients we ultimate care first and foremost
3 about their wellbeing so I would love to continue
4 that conversation with you.
5 DR. BARRON: Sure.
6 COUNCIL MEMBER LEVINE: You talked a lot
7 actually, this has been a big priority for the
8 Council, about the opioid crisis and I was
9 particularly happy to see you speak about this new
10 class of alternatives, medication alternatives, like
11 buprenorphine which far too few New Yorkers are
12 receiving. It's preferable to methadone in many,
13 many ways. It may not be right for everybody but for
14 many people it avoids having to show up to a
15 methadone clinic every day, the travel time and the
16 waiting in line and sometimes the indignity of that.
17 To just be able to have a prescription that you can
18 self-administer at home. It's just a more humane
19 option but there are major barriers to the people who
20 can prescribe this that are put on us by the federal
21 government. They're really in my opinion completely
22 indefensible but we're stuck with them since it's
23 federal so you identify a goal by 2020 to have 450
24 prescribers in your system but we're a long way from
25

2 that today, right. How many, how many prescribers do
3 you have today throughout the system?
4 DR. BARRON: Today we have 130 waivered
5 prescribers and we have a 110 waiting, trained and
6 waiting for the actual approval document from SAMHSA
7 which should be coming through within the next 30
8 days so we.
9 COUNCIL MEMBER LEVINE: That's actually
10 more than I had heard in a recent hearing. The last
11 update I had was 65 so you, you're making a lot of
12 progress it sounds like.
13 DR. BARRON: Yes, we actually area really
14 taking advantage of the training. Our physicians, we
15 have been providing, we're actually gonna be
16 providing another class next month for another large
17 group of the H & H providers because this is one of
18 our goals is really to increase the access and
19 particularly in primary care where people can get
20 their health care system, you know, their treatment
21 and it makes access more easy, it decreases stigma
22 and makes them more willing to come in to do that.
23 COUNCIL MEMBER LEVINE: Yes, that's
24 great. Well, we, we want to continue to push you and
25 medical systems around the city to get more people

2 qualified to make, to get the waiver to make these
3 prescriptions but the other side of this equation, we
4 need patients who are suffering with opioid addiction
5 also to seek out this treatment and you talked about
6 the role of peers which I think is so important.
7 They have a unique role to play in supporting
8 patients. Were you referring to the Relay Program?
9 This is an initiative that is placed, it's funding
10 peers in Emergency Rooms and maybe other medical
11 professionals so that if someone comes in with a non-
12 fatal overdose, they are told about buprenorphine and
13 they are guided to an appointment, etc.
14 DR. BARRON: Actually our program is
15 different from, it's similar but in function but
16 different from the Relay program. We are in talks
17 with OHMH about having their Relay program be a
18 supplement to ours but basically our peers that we
19 are putting in all of our Emergency Departments not
20 only see the no-fatal overdoses of opioids but we do
21 screening when people come into the Emergency
22 Department for potential substance abuse disorders,
23 particularly opioids. As part of our history taking,
24 and our screening process, people with, identified as
25 opioid users, we actually, that's where the peers go

2 in and have conversations with them really advise
3 them about options for them, buprenorphine, other
4 treatments in order to do that so it's a broader
5 program. It also goes beyond the opioid users into
6 other significant issues in our Emergency Department
7 and the alcohol users.
8 COUNCIL MEMBER LEVINE: So, so that's
9 great so every patient in every H & H facility who
10 comes in with a non-fatal overdose is screened for
11 bupren and similar class of drugs?
12 DR. BARRON: Anyone with a non-fatal
13 overdose is certainly identified yes but our program
14 goes beyond. You may have come in for a non, not an
15 overdose situation, but another medical situation and
16 we are able to screen and determine that you are also
17 using opioids, then you will be flagged for the peer
18 advocates to go talk and consult and talk with them
19 about options of getting off of opioids.
20 COUNCIL MEMBER LEVINE: Well see, you
21 said everyone is identified. I'm so sorry to be
22 parsing words on this but so everyone who comes in
23 with a non-fatal overdose at any H & H facility is
24 screened for whether these medication alternatives
25

2 are appropriate and if so, this is explained to the
3 patient

4 DR. BARRON: Yes.

5 COUNCIL MEMBER LEVINE: And a
6 prescription is offered or they are guided to an
7 appointment with a specialist?

8 DR. BARRON: We, anybody with an overdose
9 or opioid problem is seen by the peers and evaluated
10 by the treatment team and if they choose to go onto
11 the buprenorphine now, we are making available the
12 ability to do buprenorphine induction in our
13 Emergency Departments and then refer to continue
14 buprenorphine treatment.

15 COUNCIL MEMBER LEVINE: Okay, I do think
16 it's important that we have peers, perhaps paired
17 with another professional who not only can inform the
18 patient that this is available but serve as a guide
19 to make sure that they get to the appointment where
20 it's prescribed, where they get to the pharmacy where
21 it's dispensed so someone's checking in with them to
22 make sure that they're taking the medicine as
23 instructed, to make sure they come for follow-up
24 appointments. When a human being is present to help
25 offer guidance to that process, the results are

2 dramatically better and as you pointed out, peers
3 have a special, I think a special power in those
4 scenarios and I just want to make sure that every
5 patient who needs it gets that kind of guidance.
6 DR. BARRON: That's our goal too.
7 COUNCIL MEMBER LEVINE: Okay.
8 DR. BARRON: And we do follow up, the
9 peers, you know, after they leave the Emergency
10 Department, the peers including our other peer case
11 managers in our system follow up with the person to
12 sort of continue to give them that support, to make
13 sure they go for their appointments and offer them
14 support during that transition process.
15 COUNCIL MEMBER LEVINE: Great, okay.
16 Thank you for allowing me so much time with the
17 questions to both of my Chairs and thank you sir.
18 CHAIRPERSON RIVERA: Before I turn it
19 over to Council Member Cabrera, I do want to
20 recognize we've been joined by Council Member Antonio
21 Reynoso and I want to do just a quick follow up to
22 what Council Member Levine has mentioned, because in
23 your testimony you said by 2020 we will have
24 increased the number of providers to 450 who are
25 certified to prescribe buprenorphine. Do you have a

2 city wide target in mind of the number of doctors or
3 number of people who should be able to prescribe this
4 whether it’s in your system or in the voluntary
5 systems? You have a target of 450. What should we
6 be looking to push and encourage city wide from all
7 medical providers?
8 DR. BARRON: I think that may be much
9 more of a question that our Department of Health and
10 Mental Hygiene may have more information. I don’t
11 think I have enough data information to really give
12 you the appropriate estimate. I know within our
13 system our minimum goal is 450.
14 CHAIRPERSON RIVERA: I appreciate that.
15 Okay, Council Member Cabrera.
16 COUNCIL MEMBER CABRERA: Thank you so
17 much to both Chairs. Doctor, welcome. Thank you for
18 your testimony. I wanted to backtrack a little bit
19 here. In terms of the waiting time, you were
20 referring to five to six days. Is this for mental
21 health issues or for substance abuse issues?
22 DR. BARRON: Our substance abuse issues
23 are basically available the same day. We really have
24 been setting up a lot of problems. We realize the
25 issues and difficulty if a person is ready for that

treatment, you need to move on that immediately. You don't need to wait

COUNCIL MEMBER CABRERA: But let's say if I wanted to go to detox, cause I haven't heard in the whole testimony the other option. It used to be a popular one. Now, we just want to substitute one drug for another one and you know, that's, you know, it's indicative of what we need to do but if I wanted to go through detox, what is my waiting time?

DR. BARRON: You can, if you come into our system, our Emergency Room, our clinic area, and you are in need of detox, you can be admitted that day.

COUNCIL MEMBER CABRERA: Cause you know, when I talk to nurses, they tell me that they're frustrated. They're frustrated because somebody comes in and they're not readily admitted and so what I hear often, you know, sometimes even unsolicited, the question comes up, please let me know what's going on inside. They come and they tell me hey, people come and the worst thing for us is that we have to tell them we don't have a bed so this is what I'm being told on the ground floor. Is this, how do

2 you, I mean can you explain to me why we have such a
3 gap of perception here?
4 DR. BARRON: I know that we do have
5 access for detox if say there might be a case where
6 for that particular day there is no beds but if
7 someone needs detox, we don't turn them away. They
8 would be held, you know, in our Emergency Department
9 starting the detox at that point in time and then
10 moved up as soon as there was a bed available. We
11 don't turn people away, especially related to detox
12 if that is what they need and they're looking for
13 that. I think one of the things that we are also
14 doing is to, there are many different ways of
15 providing the appropriate service of detox and
16 sometimes inpatient service is not the only way. A
17 lot of people could be detoxed in a ambulatory
18 setting with a lot of extra support. We are
19 certainly looking to provide other stabilization
20 programs so that that even increases the ability for
21 people to enter the detox and/or substance abuse sort
22 of programs.
23 COUNCIL MEMBER CABRERA: So getting back
24 to the five or six days, this is meant mainly for
25 mental health related issues.

2 DR. BARRON: As I said, that's mainly the
3 mental health clinic and that's a very average across
4 our entire system. As I said, in general, they, we
5 are able to, if you were in need of services, we will
6 make sure that you have access to services, you know,
7 same day or within one day depending on the urgency
8 of the difficulty and problem and we continue to drop
9 that average length of wait time.
10 COUNCIL MEMBER CABRERA: So if it's five
11 or six days, in order to be an average of five to six
12 days, there are people who might be waiting ten days.
13 DR. BARRON: That could be possible.
14 COUNCIL MEMBER CABRERA: Do you find that
15 to be a bit too long?
16 DR. BARRON: Yes, I do and that's why we
17 are, we have active programs to really reduce and
18 improve access and reduce that wait time.
19 COUNCIL MEMBER CABRERA: And how many
20 more service providers, mental health service
21 providers are you gonna have to hire in order to
22 bring that to same day?
23 DR. BARRON: I'm not sure about the
24 number of people. I think it's also sometimes other
25 issues besides the number of providers but we are

2 certainly actively looking at that as we continue to
3 drop that length of stay, absolutely.
4 COUNCIL MEMBER CABRERA: Do you feel that
5 we have, cause I hear you gonna have to hire many
6 more mental health providers? Do you feel that we
7 have enough social workers out there and mental
8 health, do you hire licensed mental health
9 counselors?
10 DR. BARRON: Yes we do.
11 COUNCIL MEMBER CABRERA: You do. Do you
12 feel that we have enough to pool to hire from in the
13 city?
14 DR. BARRON: As you know, there's, you
15 probably know, there is a national shortage of mental
16 health professionals.
17 COUNCIL MEMBER CABRERA: Right.
18 DR. BARRON: Particularly psychiatrists
19 but also other mental health professionals. We've
20 really been engaged in an active program of
21 developing workforce, partnering with our City
22 University and other things for providing access to
23 them for appropriate internships or preceptorships.
24 We have certainly been looking at other models that
25 aren't dependent only on psychiatrists. We are using

2 more nurse practitioners. We are using more
3 psychologists, more social workers, more licensed
4 mental health counselors and professionals. We're
5 looking at using a lot more of these alternate titles
6 to really increase our ability to continue to provide
7 the care and actually expand and increase that.

8 COUNCIL MEMBER CABRERA: Doctor, I'm
9 really, really happy to hear you're tapping into
10 using licensed mental health counselors. I actually
11 started the very first Masters counseling mental
12 health program at Mercy College and at the beginning,
13 I saw the hesitation even though they have more
14 intern hours and, you know, the preparation is the
15 very good one so I'm glad you are tapping into
16 licensed professionals. Last question, is related,
17 something that you mentioned that I was a little
18 surprised to hear that you mentioned that psychiatric
19 cases, their intersection with law enforcement is
20 higher than the average person. Did I hear that
21 right cause my understanding was that it was no
22 higher than, maybe I heard it wrong but please
23 explain to me what I was

24 DR. BARRON: No, there

25

2 COUNCIL MEMBER CABRERA: To what I heard,
3 what I thought I heard.
4 DR. BARRON: No, there's not a higher
5 than average, you know, mental health, people with
6 mental illness health problems, etc. do not represent
7 a higher average in their interaction with law
8 enforcement than the general population. What I
9 meant was that, what I stated and meant was that, you
10 know, it's more difficult for oftentimes for people
11 with, that are involved with the various law
12 enforcement, criminal justice in a sense of really
13 staying in treatment and so that's why other kinds of
14 programs area being developed especially for this
15 particular population but it is a subpopulation, yes.
16 COUNCIL MEMBER CABRERA: Thank you so
17 much for that point of clarification and thank you
18 for all you do and I do agree with my colleague. We
19 do need more funding. We're talking about $800
20 million. Honestly, you need the reinforcement and
21 let me just be real, the reason why, you have a five
22 day waiting is it's just a funding issue because it's
23 all about the money. It's all about the funding and
24 it starts with us here. It's starts with the people
25 on this side and the people on the other side of City

2 Hall that you, often, I've been doing this for nine
3 years, coming before a panel and so forth and you say
4 how come you're not doing and I see Commissioners and
5 everybody saying like I wish I could say what I'm
6 about to say. I need more money in order to do it
7 and so please let us know early on to our Chairs so
8 we can advocate early on and make you part of the
9 budget so you have, we could be your quarter masters.
10 Thank you so much.
11 DR. BARRON: Thank you.
12 CHAIRPERSON RIVERA: Thank you Council
13 Member Cabrera. Yes, I too want to underline that
14 and I know Health & Hospitals has received some
15 funding from the Council in the last budget adoption
16 and please let us know specifically your capital
17 requests because we want to make sure you have the
18 best facilities to provide the best care in New York
19 City. I want to turn it over to my colleague,
20 Council Member Bob Holden.
21 COUNCIL MEMBER HOLDEN: Thank you
22 Dr. Barron for your hard work and testimony. Could
23 you describe the mobile crisis team because I would
24 think that's a very important unit to communicate
25 with some people, let's say with depression who fall

2 back and they won't answer the phone. How do you,
3 can you describe the crisis team?
4 DR. BARRON: Sure, we operate seven of
5 the city's mobile crisis teams. These, first of all,
6 let me say the mobile crisis teams currently are not
7 like 911 crisis response teams but our goal at this
8 moment is to get there within 24 hours to the crisis
9 and we are working with New York State Office of
10 Mental Health and our City Department of Mental
11 Health and Hygiene to actually reduce that number
12 through some additional work force issues. The
13 mobile crisis teams get referrals generally through
14 the Department of Health and Mental Hygiene's single
15 point of access or SPOA program. Anyone can call up,
16 family members, community members, treatment
17 resources, etc. can call and make a referral and
18 they're given to an appropriate mobile crisis team in
19 their borough, their areas, etc., things like that.
20 COUNCIL MEMBER HOLDEN: So is it, it's an
21 ambulance we're talking about?
22 DR. BARRON: No, this is basically a
23 mobile team oftentimes made up, there's a doctor
24 usually on the team. A lot of times it's made up of
25 social workers, psychologists, sometimes nurses,

2 other mental health professionals that go out to do
3 the assessment, find out what's going on, investigate
4 the crisis, make a plan of what to do. The goal
5 sometimes is to basically try to sometimes provide
6 crisis intervention services to the patient and the
7 family there to keep them in the home. If it is
8 necessary, if they need hospitalization, then the
9 crisis team usually calls the EMS NYPD to help escort
10 them to the hospital but they're not an ambulance
11 service per say but we provide a lot of ongoing
12 support to someone. We identify a crisis. Sometimes
13 it's able to be stabilized and we'll go back several
14 days in a row to provide ongoing crisis intervention
15 to the person and/or their support system to keep
16 them out of the hospital.
17 COUNCIL MEMBER HOLDEN: But is it
18 automatic, like the mobile crisis team, let's say the
19 person, you call the person, reach out, call three or
20 four times. They don't answer the phone. They see
21 the hospital is calling, caller ID. They don't want
22 to pick it up.
23 DR. BARRON: Right.
24 COUNCIL MEMBER HOLDEN: And that happens,
25 it probably happens a lot so do you have like a sort

2 of like, does that trigger something, or do we just
3 give up and decide well, this guy doesn't need help
4 or doesn't want help. I mean, I would think we need
5 more mobile crisis teams now because you said they're
6 seven in the hospital.
7 DR. BARRON: Well, there's seven in our
8 system. They're other mobile crisis teams run by
9 community based organizations in other places.
10 COUNCIL MEMBER HOLDEN: Okay.
11 DR. BARRON: There are many mobile crisis
12 teams in the city but we run seven of them.
13 COUNCIL MEMBER HOLDEN: And do you, when,
14 but do you have a, let's say a procedure that three
15 calls, person doesn't pick up. Does the crisis team
16 get involved automatically or is it just based on
17 each case?
18 DR. BARRON: I think you're asking like
19 if we saw someone that's not going to their
20 appointments that we, let's say, you got discharged
21 from an inpatient service and you missed your
22 appointment at your outpatient clinic. We would make
23 those calls to see, yes we have kind of a procedure.
24 One, when someone's discharged, they may be rated as
25 high risk or moderate risk or low risk. If they are

2 mid or moderate or high risk and we can't get in
3 touch with them through our follow-up system then
4 usually we, yes, refer that to mobile crisis teams.
5 COUNCIL MEMBER HOLDEN: I just want to
6 know if there's anything like if it's a moderate
7 risk, if it's a high risk, does the mobile crisis
8 team get involved?
9 DR. BARRON: Yes, yes.
10 COUNCIL MEMBER HOLDEN: All right, and
11 regarding the homeless and going back to my
12 colleague's question about reaching out to the
13 homeless, does the crisis team get involved with the
14 homeless situation? Obviously they need it.
15 DR. BARRON: We, we do. It makes it more
16 challenging and difficult. I mean if it's one of our
17 patients we've treated and they're homeless, the
18 homeless situation can make that ability to find the
19 person more challenging and difficult. Oftentimes we
20 work with the community based homeless agencies that
21 go out and are really much more familiar with some of
22 the issues related to the homeless so our mobile team
23 oftentimes partners with them to reach someone who is
24 homeless. As I said, our goal really is to try to
25 get someone with mental illness and homelessness into

some other kind of setting, whether it be, you know, supportive housing or something but yes.

COUNCIL MEMBER HOLDEN: Yes, just one, maybe you have an observation or some thought on this. How do we get more volunteer hospitals involved in behavioral health? Is there an incentive we can give, the city can? Do you have any ideas on that?

DR. BARRON: Well, individual hospitals may have individual issues, you know, that I don't have the data. I mean in general, behavioral health services are very important. As we see, sometimes they are, it's the reimbursement of them are difficult and you have to offset them with other services. It's hard for me to comment on what other hospitals have, reasons, their data and individual of why they may or may not be involved in systems. I think that there are many that certainly are very active and involved.

COUNCIL MEMBER HOLDEN: All right, thank you.

CHAIRPERSON RIVERA: Thank you Council Member Holden and I just want to point out I don't think there are any representatives from voluntary

2 hospitals here today. You can correct me if I'm
3 wrong and you are free to submit a form to testify.
4 Thank you. I would like to go to Council Member
5 Alicka Ampry-Samuel.
6 COUNCIL MEMBER AMPRY-SAMUEL: Thank you.
7 Hello, hello. Is it on?
8 COUNCIL MEMBER REYNOSO: Test.
9 COUNCIL MEMBER AMPRY-SAMUEL: Ohhhh,
10 okay.
11 [Laughter]
12 COUNCIL MEMBER AMPRY-SAMUEL: It wasn't
13 on before.
14 CHAIRPERSON RIVERA: They're on all the
15 time, just FYI.
16 COUNCIL MEMBER AMPRY-SAMUEL: First,
17 thank you so much for this hearing. About say,
18 almost 20 years ago I worked as a discharge planner
19 on an inpatient psych unit. I worked at Mary
20 Immaculate Hospital in Jamaica, Queens before they,
21 well when they first opened up the Five New Unit
22 which was a 28 bed facility and was hurt when they
23 had to close down and I think I spent most of my time
24 as a discharge planner looking for organizations and
25 different programs to discharge to outside of the

2 partial that we had across the hall and so thank you
3 so much. This is very critical and I also worked on
4 the mobile unit with Guided Riverside Project Reach
5 Out a little, about 21 years ago and so it's
6 interesting how we're having this conversation, the
7 same conversation 20 years later but I want to go
8 back to Councilwoman Ayala's question related to
9 children. I had a young man who attempted suicide in
10 middle school and my question is really related to
11 H & H and it's collaboration with the Department of
12 Education as well as its collaboration with the
13 Administration for Children's Services because I just
14 feel like the system failed this young man. He went
15 to school and attempted suicide in the bathroom and
16 was immediately hospitalized and then was removed
17 from his parents and then went through the system and
18 was hospitalized for a couple of weeks and from his
19 foster home was just dropped back off with like a van
20 service directly to the school again and the school
21 had no idea as to how to be able to be supportive of
22 this young man and they were not able to contact the
23 family anymore and it was just all about the City of
24 New York and this went on for about several month
25 later the child would be hospitalized, go back to his

2 group home and just be dropped back off in front of
3 the school and it was just constant and the
4 principal, the administration and the teachers were
5 just frustrated with not really having like a
6 protocol or a system or something in place to really
7 be of support and actually know what was going on so
8 you mentioned school based programs so can you just
9 elaborate on what that really means and look like and
10 situations where some of our children really are in
11 crisis but are just shuffling through the system and
12 they don't have their family support or that
13 traditional family support.
14 DR. BARRON: So Health & Hospitals does
15 operate a number of mental health programs both
16 mental health and oftentimes health care, primary
17 care, pediatric care in a variety of schools
18 throughout the city where we provide basically mental
19 health services including assessment. It includes
20 ongoing, you know, therapy. It might be medication
21 management by the psychiatrist associated with the
22 program but a lot of times it's therapy with the
23 person, the adolescent, the individual in the school
24 and oftentimes the family. Where there are family
25 involved, we encourage, you know, to have not only

individual sessions but family sessions when appropriate. We also actually provide a lot of education and support to the school faculty, the teachers, the counselors, all of those where we are located in any of those, that's a big support that we try to play for that and we see a number of success of kids coming, you know, to these mental health services. We make them accessible, we make them so they're not stigmatized, so they're somewhat informal so that they can come to the services so that we can have an opportunity to provide treatment services to them but also education services about mental health issues as well.

COUNCIL MEMBER AMPRY-SAMUEL: So is that something that all schools are familiar with so maybe this particular principal of particular school just didn't know what was available or a kind of standard?

DR. BARRON: I don't know that there, I don't know that there is a formal, you know, mental health program in every school. They're certainly, you know, that we have targeted a lot of schools with particularly a lot of issues and known mental health and substance abuse and other behavioral problems but I certainly think it's a very important program. I

2 know that the city is certainly looking to increase
3 the number of school based programs that are
4 available because we do find it does make a
5 difference in providing that support for the children
6 as well as for the teachers.

7 COUNCIL MEMBER AMPRY-SAMUEL: Okay, and
8 this is my last question. Can you describe how H & H
9 links individuals who receive psychiatric care while
10 incarcerated to continued care services once they are
11 released because myself and Council Member Holden
12 recently did a visit to Rikers Island and we had just
13 so many questions related to what happens next.

14 DR. BARRON: I'll say, I'll do the best I
15 can. My colleague who had to leave, she's here.

16 [Laughter]

17 DR. BARRON: This is Dr. Elizabeth Ford
18 with Correctional Health.

19 CHAIRPERSON RIVERA: We want to make sure
20 you get sworn in.

21 DR. FORD: Sure, absolutely.

22 CHAIRPERSON RIVERA: Do you affirm to
23 tell the truth, the whole truth and nothing but the
24 truth in your testimony before this Committee and to
25 respond honestly to Council Member questions?

DR. FORD: I do, yes.

CHAIRPERSON RIVERA: Thank you.

DR. FORD: Apologies, I was just about to go but I, your question was reentry services I believe for individuals who are detained in the jail system, am I correct? So we have a high proportion of individuals detained who have serious mental illness and also less severe forms of mental illness and for each person that the mental health service in the jail treats, we provide reentry services that run the range from entitlements, housing, treatment services, education and employment opportunities and each of those plans, the discharge plans is pretty individually tailored for the person's specific needs and we are connected to multiple community agencies both within Health & Hospitals and outside for those people.

CHAIRPERSON RIVERA: Thank you, Council Member Moya.

COUNCIL MEMBER MOYA: I want to take this opportunity to thank the Chairs for really doing a wonderful job of bringing this hearing together. Chair Rivera and Chair Ayala, thank you. This is a problem when you're like batting clean-up. Most of

2 your questions are already answered but I just wanted
3 to take this opportunity to thank my sister, Arlena
4 Moran. We're both national urban fellows. I know
5 she was here a moment ago and we worked together at
6 Elmhurst Hospital and she's doing a tremendous job
7 and thank you doctor for your testimony and everyone
8 who is doing a tremendous job in helping to combat
9 these issues that we're facing here in our city so
10 thank you, Chairwoman for allowing me just to shout
11 out to my sister, Arlena, who is a good friend of
12 mine. Thank you.
13 CHAIRPERSON RIVERA: Thank you Chair Moya
14 for your shout out and your comment.
15 [Laughter]
16 CHAIRPERSON RIVERA: That was nice. It's
17 important that we, you know, these are everyday
18 heroes. I know a lot of you are in this room right
19 now so thank you for being here. Council Member
20 Reynoso.
21 COUNCIL MEMBER REYNOSO: Thank you,
22 Chair, Chairs for this hearing. So just like Council
23 Member Moya, my wife has just graduated from Beirut
24 [phonetic] for mental health in their graduate
25 program so I'm extremely proud of her and happy that

2 I was a test subject or the guinea pig for many of
3 her experiments but she graduated and I think I'm
4 okay. I think I'm better now than I was when she
5 started the program.
6 [Laughter]
7 COUNCIL MEMBER REYNOSO: Sometimes I
8 didn't think I was though but I do want to ask,
9 related to reimbursement, the money question. It's
10 always about money but H & H and Dr. Katz has said
11 they have a plan to get out of this hole and this
12 debt that we have in our Health & Hospitals system.
13 Reimbursement is extremely important and the easier
14 the reimbursement is, the more he wants to make sure
15 he's paying attention to it and focusing on it.
16 Mental health is reimbursed differently than general
17 health, right and it just doesn't seem like it would
18 be on the top of our priority list of where we need
19 to expend resources on hiring let's say more mental
20 health professionals to be supply or I guess do the
21 work if it's not easy to reimburse and if it's not,
22 if it doesn't, the return, I guess, on how much it
23 costs will be how much is received as a city so I
24 just want ask, is it a top priority, what's the
25 reimbursement method, just in general, is this gonna

2 be something that we are gonna pay attention to long
3 term or are we just kind of just rolling with it?
4 DR. BARRON: Well, that's a terrific
5 question. Thank you for letting me answer that.
6 Actually Dr. Katz is very committed to continuing
7 behavioral health services. He recognizes the
8 importance of these services in health care in
9 general and certainly in New York City in particular
10 and he has made a strong commitment to continue these
11 services, to advocate for appropriate reimbursement
12 and to look for other opportunities as he testified I
13 think in budget hearings in the sense of looking at,
14 you know, our current different strategies for
15 revenue management. Also looking for other kinds of
16 services that maybe having a higher reimbursement,
17 where appropriate, it would offset our, some of the
18 behavioral health issues so he's really made a very,
19 a long term commitment to us and I think the fact
20 that we are the main behavioral health provider in
21 New York City and I think that commitment is
22 appropriate.
23 COUNCIL MEMBER REYNOSO: So the higher
24 reimbursements subsidizing the work we do with mental
25 health, that's baked into our plan?

2 DR. BARRON: Well, that's one of the
3 aspects of that. We're looking at many of our, you
4 know, any, wherever we can improve the reimbursement
5 and the collection on mental health services, making
6 sure that anybody who is eligible for benefits or
7 coverage. They'll be a system helping them to sign
8 up to get that coverage. Oftentimes many of our
9 people with mental illness do qualify for that but
10 maybe they've not been able to, for a variety of
11 issues including maybe their illness, sign up and
12 achieve that status so we're certainly part of the
13 program of looking at making sure that everyone who's
14 appropriate is insured, looking that all of our
15 services are appropriately billed to the insurers and
16 then also then looking at other areas we can offset
17 some of the other things.
18 COUNCIL MEMBER REYNOSO: Just want to
19 make a push and advocate. I know that this panel
20 most likely agrees that the separation of like
21 physical health and mental health and how they're
22 reimbursed and what they're looked at in relation to
23 just general health, it's not something that we're
24 proud of. I think the federal government is the
25 biggest issue so I want to be clear that the City

2 Council is clear of the responsibility regarding the
3 fact that they're treated differently when they
4 should be the same but that reimbursement is
5 extremely important and for the long term financial
6 health of this Health & Hospitals, just want to make
7 sure we're all on the same page. That it is
8 something that is being prioritized and it's not
9 being on back burner sometimes because it's not, it
10 does have a high reimbursement rate. The next thing
11 I want to ask, the last question is I'm having, I
12 have huge issues when the Police Department is the
13 first responder to much of these mental health issues
14 in the City of New York and what we're seeing in a
15 lot of cases, these officers don't know how to
16 properly assess the mental health victim, let's say,
17 and end up shooting them and killing them for lack of
18 experience and lack of education. To be honest, it
19 shouldn't be the police's responsibility to show up
20 at any situation where there's a mental health person
21 and a lot of times these are mostly happening in
22 communities of color as well that are poor
23 communities where people are often misjudged or, you
24 know, the racial bias that exists in a lot of work
25 that the police is doing. I heard about these

2 emergency or these mobile units. Is there a
3 conversation happening in the administration where
4 they're tying the two together where we're gonna
5 figure out a way that when there is a call made and
6 we hear that it's a mental health person, a person
7 that needs mental health assistance, that maybe we
8 send you instead of the cops?
9 DR. BARRON: There is a conversation
10 going on. Actually, the task force has just been
11 formed and it's meeting with the goal of really
12 looking at crisis response and to emergency
13 situations so we're looking forward, we're a part of
14 the task force. Dr. Katz is on the Advisory
15 Committee of that and many of our other behavioral
16 health experts are participating in work groups so
17 we're looking at how to really best answer some of
18 those questions. There are a couple of co-response
19 teams already where their mental health professionals
20 go with the police when there's a suspicion of mental
21 illness which seems to be a successful part so I
22 think that there is a conversation looking at how to
23 improve that.
24 COUNCIL MEMBER REYNOSO: I appreciate it
25 and I'm looking forward to a report of whatever,

2 anything that comes out of that. That's an extremely
3 important issue. Again, I want to thank both Chairs
4 for this great hearing and thanks Dr. Barron for your
5 testimony and the work that you do.
6 DR. BARRON: Thank you.
7 CHAIRPERSON RIVERA: Council Member
8 Ayala.
9 CHAIRPERSON AYALA: So I have a couple
10 more questions. I know you are ready to leave, every
11 time you're ready to leave
12 [crosstalk]
13 CHAIRPERSON AYALA: We apologize but the
14 last question. Because you guys are doing work at
15 Rikers Island, and we know and understand really well
16 that not every inmate is getting the attention or the
17 services they require because of the issues with the
18 way the facility was built and security, I want to
19 understand a little bit better. What happens when
20 you have, when you're treating a mentally ill inmate?
21 How does, is there coordination with the Corrections
22 Department as it pertains to disciplinary action to
23 that, inmates that may be suffering from maybe
24 bipolar disorder or depression like not being put
25 into solitary confinement as a means of, you know,

2 punishing them for bad behavior which should be
3 expected under the circumstances? If you could
4 DR. FORD: Yeah, absolutely. Thank you
5 for that question so as of December 31, 2013,
6 individuals with serious mental illness such as the
7 bipolar disorder that you mentioned do not go into
8 solitary confinement or punitive segregation and we
9 have developed since then fairly substantial and very
10 effective alternatives to punitive segregation for
11 individuals with serious mental illness who would
12 have otherwise been there but as of today, there is
13 not a person with a serious mental illness in
14 solitary.
15 CHAIRPERSON AYALA: Can you elaborate on
16 that a little? What does the treatment look like?
17 DR. FORD: Sure, it's a, there are units
18 called CAPS, clinical alternative to punitive
19 segregation, and they started in early 2014. They
20 are treatment units within the jail system that are
21 modeled after inpatient psychiatric units so they are
22 richly staffed with both mental health staff as well
23 as steady Department of Correction officers who are
24 trained as a team together to take care of the
25 patients. There is as much as confidentiality and

2 protective health information will allow. The health
3 staff and the custody staff work very closely
4 together with these patients. There are lock out
5 models which means the people are not locked in their
6 cells and they, with the exception of being in a
7 jail, they look fairly similar to the care they would
8 get in a hospital.
9 CHAIRPERSON AYALA: Okay, I appreciate
10 it. Thank you.
11 DR. FORD: Sure.
12 CHAIRPERSON RIVERA: And I also want to
13 add that the Chair, the Committee on Hospitals that
14 is chaired by yours truly and I also serve on the
15 Committee on Criminal Justice and we're planning to
16 do a joint hearing on correctional health in October
17 of this year so thank you for your testimony. Just a
18 couple more questions, I don't know if any of my
19 colleagues have anything further but just to ask you
20 about recruitment. Earlier today you mentioned
21 Dr. Katz commitment to hiring more primary care
22 physicians and increasing this network as a way of
23 moving towards prevention rather than intervention
24 because of the move towards ambulatory care. So how
25 is H & H dealing with the recruitment of new

2 psychiatrists to care for the patients in this move
3 of more primary care?
4 DR. BARRON: Well, we certainly advocate
5 for recruitment of psychiatrists whenever we have the
6 availability of needing psychiatrists or vacancies,
7 etc. As I mentioned, there is a national shortage of
8 specifically psychiatrists and particularly in the
9 larger of an area such as New York so we are looking
10 at how to better use our psychiatrists that we have
11 and develop a lot of other alternatives. We really
12 are developing models that use physician extenders as
13 we call them, nurse practitioners, psychiatric nurse
14 practitioners, social workers, psychologists really
15 to work with the team with the physician, the
16 psychiatrist to provide care so that basically the
17 psychiatrist is able to really focus a lot on the
18 kinds of treatment skills that only the psychiatrists
19 do such as doing psychopharmacology and doing sort of
20 overall treatment guidance of the patient's care and
21 then some of the other things like the therapy and
22 other things that are really very important are done
23 by some of our other physician extenders. We're also
24 developing the technology and are using
25 telepsychiatry. It's very widely used in the rest of

2 the country and certainly in certain situations that
3 would be ideal, especially providing consultations to
4 small clinics, to our primary care providers so we
5 are developing that model as well to provide
6 consultation and treatments as well as psychiatry.
7 It allows us to have the greater service and not be
8 so dependent on the shortage of psychiatrists that
9 the country is feeling.
10 CHAIRPERSON RIVERA: I know you said
11 there's a move towards telepsychiatry but do you
12 think it's effective?
13 DR. BARRON: It has, there have been
14 certainly studies and things that have shown that it
15 has been effective and that also that the patients
16 receiving that can be very satisfied. A lot depends
17 on how you set it up. In our model, there will be
18 someone with the patient like potentially a
19 counselor, a social worker or something of that
20 nature so the psychiatrist would do that through
21 that. We are experimenting a lot with consultation
22 and certainly sometimes we have shortages of say for
23 example, child psychiatrists in our system. We can
24 use some of our child psychiatrists to provide
25 psychiatric consultation to our colleagues that are

2 on site, our general psychiatrists and the primary
3 care providers.
4 CHAIRPERSON RIVERA: With the mention of
5 data, I do want to ask in your testimony you
6 mentioned deploying a system wide and multi-phase
7 expansion of the integrated ambulatory behavioral
8 health care and that's with a expected completion
9 date of 2020 and I wanted to know when you're
10 assessing your facilities and determining what kind
11 of services you're gonna provide related to social
12 determinants, if there is any data that you can share
13 with us on that fully realizing that a lot of it has
14 to remain anonymous to protect people's sensitive
15 information but if you had any information that could
16 help us in how you do facility assessment and service
17 provision related to social determinants, we would
18 really appreciate that data so that's one request
19 from me and then you mentioned the national shortages
20 of psychiatrists, I agree. I know that it is a big
21 issue and even the primary care physician shortage is
22 also a very big issue nationally so you have, for
23 example, recently the Allen Pavilion at Presbyterian
24 closed and there was an elimination of behavioral
25 health beds and so I have reason to believe that you

2 will actually, this hospital itself will be directly
3 affected because of just its geography so is your
4 hospital prepared to take on that capacity and when
5 we mentioned national shortage of doctors, how does
6 that impact the nurses that are here and what they're
7 going through in terms of staffing ratios and
8 patients.
9 DR. BARRON: Well I think it's, while
10 we're certainly concerned about taking away of the
11 capacity and we would certainly, I think, we're gonna
12 have some challenges in absorbing additional capacity
13 than we already do but we certainly, our mission is
14 to serve, so we certainly won't turn anybody away. I
15 think our shortage of psychiatrists is a concern
16 every day for us is to make sure that we have
17 appropriate staffing levels. In relation to nursing,
18 you know, we've actually hired a number of nurses.
19 Actually, we since I think it's January, we've hired
20 about 400, the exact number, I think it's 450 nurses
21 and they are in various stages of onboarding and
22 orientation. There are 60 in the class here in June
23 so we recognize that nursing actually plays a very
24 vital role in health care and in specifically in
25 behavioral health so we've been making a lot of

2 efforts to, you know, really increase our nursing
3 capacity, etc. I think, you know, the shortage of
4 psychiatrists impacts the entire team. In behavioral
5 health, you really, you function as a team. The
6 doctor, the nurse, the social worker, the
7 psychologist, the mental health professional, all of
8 that, we function as a team working with our patients
9 so it impacts certainly our teams but that's why
10 we've really been developing some other models and
11 what we have seen with our models is basically a lot
12 of success. We see a lot of patient satisfaction.
13 We see improvement in our patients. We see, also,
14 improvement in our satisfaction of our staff as well.
15 They find this to be a very good model for them to
16 work.
17 CHAIRPERSON RIVERA: Well, I know we're
18 gonna hear from the nurses shortly so I encourage you
19 to stay for all testimony. We don't have a ton of
20 people here so I really do encourage the
21 administration to stay and listen to everyone who is
22 here. So I wanted to just ask whether, I know that
23 we had mentioned earlier the budget and my colleague,
24 Council Member Cabrera said to let us know how we can
25 be a partner in supporting you as a system and

2 whether there was anything you felt that our
3 committee could do to support your work and bring
4 resources or visibility or awareness to some of what
5 you're doing and how we can support you serving the
6 majority of New Yorkers who are seeking behavioral
7 health services. Have you had any ideas?
8 DR. BARRON: I will get back to you. I
9 definitely may have some ideas. Thank you very much.
10 That's important.
11 CHAIRPERSON RIVERA: Sure, I mean I want
12 to honestly. This is not just about your system.
13 Unfortunately, like I said, there aren't voluntary
14 hospitals here and we have a lot of questions about
15 their decision to eliminate behavioral health beds
16 and we all know when it comes to the bottom line and
17 reimbursements, what services make more money than
18 others and so we want to make sure that there is
19 equity in this system city wide and the burden is not
20 just on H & H so if there's not any further questions
21 from my committee members, I have a few more and I
22 think what we'll do is send them over to you.
23 There's some, data driven again, my request for data
24 on some of the social determinants. We're gonna have
25 the correctional hearing in October and we plan to

2 dive pretty deep into that and I just want to thank
3 you for being here and answering all our questions
4 and for holding your own, just like right then on
5 your own.

6 DR. BARRON: Thank you very much. Thank
7 you for your support.

8 CHAIRPERSON RIVERA: Oh you're very
9 welcome, oh, oh and I want to acknowledge Council
10 Member Powers and put him on the spot and ask if he
11 had any questions.

12 COUNCIL MEMBER POWERS: I have no
13 questions. I congratulation you both on doing a
14 hearing. I was just out in the field, actually at a
15 school a block away and I wanted to come see these
16 two talented Chairs in action so

17 CHAIRPERSON RIVERA: Keith, I mentioned
18 you. I said we're having a correctional health joint
19 committee hearing.

20 COUNCIL MEMBER POWERS: Yes.

21 CHAIRPERSON RIVERA: Council Member
22 Powers who has Bellevue Hospital where I was born. I
23 just want you to know something personal about me.
24 So thank you again. Thank you Dr. Barron. We're
25 gonna move on to testimony from members of the public

2 and we will be sure to follow up with you in the
3 future immediately following. Thank you.
4 [pause]
5 CHAIRPERSON RIVERA: Oh, okay, so I would
6 like to call up Judith Cutcheon [phonetic], a
7 registered nurse, Ann Bovay [phonetic], a registered
8 nurse and Jeanine Thomas from DC37.
9 [pause]
10 JUDITH CUTCHEON: Good afternoon all. My
11 name is Judith Cutcheon. I'm a registered nurse and
12 work at Woodhull Hospital for over 27 years and I'm a
13 R.N. for 28 years. I'm also with the New York State
14 Nurses Association Executive Council, Health &
15 Hospitals and Mayoral Executive Counselor President
16 representing over 9,000 nurses. First all, I want to
17 thank you all for allowing me to address you here
18 today and then the Chair for these committees, Ms.
19 Diana Ayala, Mark Levine and Carlina Rivera for
20 highlighting the very, very important issues. I want
21 you to know that we, the 9,000 nurses of the Health &
22 Hospitals Corporation and Mayorals stand ready to
23 work with you to do what we can to stop further
24 exacerbation of the issues that I will discuss and to
25 support the expansion of mental health services and

2 funding in our hospitals and our facilities. I would
3 like to share some information with you. As you may
4 know, State run psychiatric facilities in New York
5 began to close in 1982 and State run facilities with
6 psych bed have declined by 90% from 1982 until the
7 present. This has left a severe burden on New York
8 public hospitals, especially in Health & Hospitals
9 Corporation and some safety net facilities. There
10 are more than 2,840 hospital beds for psychiatric
11 patients at a total of 37 hospitals across the five
12 boroughs. Almost half of the available beds are in
13 the City public hospitals. Three of those hospitals,
14 Bellevue in Manhattan, Kings County in Brooklyn,
15 that's where I was born, and Elmhurst Hospital. They
16 account for 25% of all psychiatric beds in the city.
17 Thirty percent of all beds in public hospitals for
18 psychiatric patients while only 8% of all beds in the
19 private system are for psych patients which is an
20 extremely low number compared to the public hospital
21 system. Nearly 40% of adult New Yorkers with serious
22 mental illnesses, 95,000 individuals, did not receive
23 mental health treatment in 2017. The continual
24 removal of hospital beds and the funding of mental
25 health treatment will only exacerbate this issue.

2 New York State Nurses Station 1199, Interfaith
3 Medical Center in Brooklyn, Kingsbrook Jewish Center
4 in Brooklyn, students, community groups conducted a
5 2017-2018 community health study in Bed-Stuy, Crown
6 Heights and east Flatbush. The results were very
7 astonishing. The number one response to the
8 community of health was housing insecurity. A
9 majority of those surveyed attributed for if they
10 would afford to live in their homes for another five
11 years. You should know that hospitalization rates
12 for mental illness including schizophrenia and mood
13 disorders are two times as high in displaced people
14 versus those who remain in their neighborhood.
15 Nearly one million New York City residents are at
16 risk of being priced out of their homes with enormous
17 implications for mental health care needs. This
18 stressor of housing insecurity is placing our
19 communities and our patients under a massive amount
20 of mental stress. Ending housing gentrification and
21 addressing mental health are immediate needs of our
22 communities. The two issues, they definitely go hand
23 in hand. Mental illness is linked to other
24 illnesses. There is also a strong link between
25 mental health and chronic conditions such as

2 diabetes, cancer and heart disease to name a few.
3 Many of our patients are presenting themselves with
4 whole host of illnesses. Mentally ill patients are
5 not coming into our hospitals and facilities with
6 just one condition. Our patients are truly sick.
7 They are coming to the ambulatory setting sick and we
8 need to treat the whole scope of their illnesses
9 including the mental health. Our government
10 institutions has an obligation to make sure mental
11 health services are fully funded. As previously
12 stated, only 8% of New York City's private hospital
13 beds are for psych patients. Most private hospitals
14 have abandoned the mental health. The insurance
15 companies as well. It is only the safety net
16 facilities both public and some private like
17 Interfaith Medical Center and Health & Hospitals
18 Corporation that are doing their part. It is high
19 time that we work together, the city, the state and
20 at the federal level to provide safety net
21 institutions with proper funding levels especially
22 for the lion's share of mental health services that
23 we provide in these communities. There is one final
24 thing to say. We at Health & Hospitals are open for
25 care. We want care and care well for all of our

2 patients and the communities we serve. Our doors are
3 open for care and we need increased adequate funding
4 for mental health safety now better than later.
5 Thank you.
6 CHAIRPERSON RIVERA: Thank you,
7 Ms. Cutcheon for your comments on housing and how it
8 affects our mental health as a city and the crisis
9 we are in and, of course, I have to thank you for
10 your 28 years of service
11 COUNCIL MEMBER REYNOSO: At Woodhull.
12 Thank you very much for your service.
13 CHAIRPERSON RIVERA: I was going to say,
14 at Woodhull. The whole time you've been at Woodhull?
15 JUDITH CUTCHEON: Except one.
16 COUNCIL MEMBER REYNOSO: There you go.
17 That's why she's amazing.
18 CHAIRPERSON RIVERA: I'm sure you've
19 served any number of my family there out of Bushwick
20 Houses. Okay, thank you so much. Ann, Ms. Bovay,
21 excuse me.
22 ANN BOVAY: My name is Ann Bovay and I
23 recently retired from Bellevue Hospital after a long
24 time of service. It's been 40 years, okay.
25

2 CHAIRPERSON RIVERA: It's on the record
3 as 40.
4 ANN BOVAY: It's actually there, okay.
5 [Laughter]
6 ANN BOVAY: I did put it there but it's
7 amazing to me, I guess what disturbs me most, a lot
8 of what I had there is a lot of statistical analysis
9 but that the bulk of behavioral health management
10 here is done by the public sector and that the
11 private sector has abandoned it and it doesn't matter
12 your income. It really doesn't matter your income.
13 It's just the idea of that particular service. When
14 I think of 40 years ago when I started at Bellevue
15 and I think of the services that are provided at
16 Bellevue now, one of the services that I feel has
17 been lost, that really need to be reinstated is those
18 transitional services whereby the patient is
19 discharged but still has a connection with the
20 facility to ensure that's a continuation of treatment
21 modalities necessary to facilitate the care that
22 needs to be done. The other, the other thing that is
23 also quite disturbing is the fact that in terms of
24 looking at our Emergency Room settings, there needs
25 to be restructuring in the sense of actual

2 architecturally because right when I was retiring
3 there were 16 people that were out, nursing personnel
4 that were out because of injury in psych emergency
5 and a lot had to do with the structure of how's the
6 psych emergency set up and diversion is just a word.
7 It's not a reality so that if that Emergency Room
8 gets, you know, over censused to like 50 people, they
9 really can't send people away and you have stretcher
10 on top of stretcher on top of stretcher. I know the
11 CEO of the hospital has put forward a capital budget
12 to put that change in place but where it stands now
13 is in this nebulous world that can't be nebulous any
14 more. Also another thing that was mentioned was the
15 idea of handling people and the idea of crisis
16 management and that crisis management training needs
17 to be throughout the system. Every nursing personnel
18 at Bellevue gets crisis management trained and it's
19 my belief that anybody who deals with the public,
20 NYPD, FDNY, anybody needs that crisis management
21 training. How do you deescalate a situation and it's
22 my understanding that this doesn't happen in the same
23 way that it's happened at Bellevue. Just like BLS,
24 basic life support, you can't just watch a film for
25 four hours and say, you know, that's okay. You have

2 to actually be sure you know how to do it and it's
3 this idea of de-escalation and you are recognizing
4 someone is crisis and understanding how that
5 ultimately impacts and not only impacts from a
6 behavioral health standpoint but the immediate
7 physiologic changes that an individual may have in
8 the process of de-escalation and that if they do have
9 any critical physical issues like cardiac, etc. that
10 they're more prone to show it in that de-escalation
11 phase, you know, when they are recuperating cause now
12 their adrenaline is gone accordingly. You know, so I
13 think that there's certain measures that can done.
14 I'm glad that there's more nursing personnel being
15 hired but what disturbs me is they're let it get to
16 such very difficult numbers and that if you are
17 hiring, you know, X number, hundreds of nurses for a
18 facility, what's that telling you, you left it at and
19 I'm retired a year ago and they still haven't
20 replaced my position. Who's there to educate, who's
21 there to be the role model? Legacy was not
22 considered and Legacy with the New York Health &
23 Hospital needs to be considered because at, in terms
24 of my age bracket and within a ten year span, a lot
25 of people are gonna be retiring just simply because

2 they aged out. I tried to explain that to leadership
3 in New York City Health & Hospitals but it wasn't
4 grasped so just to understand that people aren't
5 abandoning the system. When you hit and you're 60+,
6 I won't say age, you know, that's the time you need
7 to now yourself transition and the certain physical
8 capabilities that may be a challenge for you as well
9 so in final summary, the idea of early recognition in
10 terms of crisis management. You know, financial
11 support for providing the facility necessary to
12 manage the patients that New York City Health &
13 Hospitals sees in a safe and efficient manner and
14 just, you know, planning ahead, not doing catch up in
15 terms of providing those resources. Thank you.
16 CHAIRPERSON RIVERA: Thank you, Ms. Bovay
17 for your years of service and for your testimony
18 which actually has a lot of information on recent
19 beds that have been eliminated in the voluntary
20 network.
21 ANN BOVAY: Just one point on Allen
22 Pavilion.
23 CHAIRPERSON RIVERA: Sure.
24 ANN BOVAY: That got postponed for one
25 year because they did hire and renew the visit but

2 that's just one year and what's gonna happen after
3 that year. You know, we're not forgetting and that
4 community needs to have that service. Thank you.
5 JEANIE THOMAS: Good afternoon. My name
6 Jeanine Thomas. I am a Council representative for
7 District Council 37. I've been involved with the
8 Union since 1981. I've worked at the New York City
9 Police Department, Rikers Island and Health &
10 Hospitals. I don't have a speech but I was taking
11 notes about a lot of things that was said. The
12 issue, there is a shortage of psychologists and
13 psychiatrists in the hospitals but you have other
14 staff members that can help the patients. The
15 problem is everybody knows its funding and hospitals
16 that I covered. I've covered Woodhull. I've covered
17 Harlem and I've covered Lincoln Hospitals and the
18 behavioral health in all of them. They are terribly
19 short staffed. Sometimes you have a 20 to 1 ratio
20 with one person watching 20 patients. The vision of
21 Health & Hospitals that I read is for the behavioral
22 health department to have a therapeutic environment
23 so you would decrease recidivism. That is impossible
24 when you have staff that cannot really
25 therapeutically attend to the patients because

2 they're short staffed so what you have is a type of
3 thing where patients just come in for crisis. They
4 go out. Most of the social workers that I cover, I
5 cover many titles, have shared with me that they only
6 have time to do a exit as one of my sister here
7 testified that she used to work in discharge
8 planning. They tell me that's the bulk of what they
9 can do so you don't have on a large scale the
10 patient's getting connective outreach. You have a
11 little bit of that in Harlem and it's being
12 successful. I even hear some patients on the
13 elevators saying that they like that but on a full
14 scale, you don't have that. With that you have the
15 Rikers Island. I was with them when they went
16 through the change when Mayor De Blasio's wife
17 decided that, you know, mental patients should be not
18 criminalized but seen another way so now you have a
19 different culture coming into the hospitals. You
20 have more injuries of the staff. They're being
21 injured. The forensic units are not being used to
22 move the violent patients to other facilities like
23 Bellevue which is great for that so you have a lot of
24 things going on. I truly believe looking at the
25 glass half full that it can be done but with the

staffing levels the way it is when you have one person watching 20 patients, there are some patients that come in. They're not really in crisis. They just need a break from life. The situation that they're put in because of the atmosphere doesn't even help them get well. They complained as well so without the staffing, without them moving to hire, not just nurses and psychologists but you have other titles. You have BHA's which they hired so that they could keep the hospital police out of treating patients like criminals. You have a very short staffing level with them and so the staffing level means a lot. I have to say it again, staffing, staffing, staffing because when you don't have people that can report to the psychologist, that deal with the patients on a everyday basis and they don't even have time to record the patient's actions, pretty much what's happening with the patients is presumptuous, therapeutic care and so I live in the city and I work for the Union and I'm very much concerned about the decrease in recidivism plus, last point, when you don't take care of mental health care because now it's in every department in the hospital. It's just not in behavioral health. We have folks

2 coming in different places and you begin to see that
3 they have these mental issues. When you don't take
4 care of the hospital, it spills outside and so now in
5 front of the hospital you have the homeless, you have
6 the mental ill and when they get hungry or cold or
7 tired, they do stuff so that the police can arrest
8 them. They know they're not going to jail and they
9 come in and now you have a whole another situation
10 where you are creating a hospital environment inside
11 the hospital and out so with everybody looking at
12 this as a good thing because New York City really
13 needs it but staffing, staffing, staffing, staffing,
14 staffing, you are not having a therapeutic
15 environment, you're not having things get better.
16 What you're doing is you're just moving people in and
17 moving them out and after ten years, we're gonna be
18 worse off. Thank you for hearing my testimony.
19 CHAIRPERSON RIVERA: Thank you Ms. Thomas
20 for your multi-borough service as well and for
21 bringing up staffing. We know how important it is
22 and I'm glad to see a lot of nurses and nurse
23 representation here so are any other members of the
24 public who wish to testify?
25

2 COUNCIL MEMBER LEVINE: I have a
3 question.
4 CHAIRPERSON RIVERA: Oh yeah, sure
5 actually. Any Council Members have questions for the
6 panel, please.
7 COUNCIL MEMBER LEVINE: Thank you, thank
8 you Madam Chair. This testimony from all three of
9 you was so powerful and so necessary. I'm really
10 glad that you came and spoke out. I'm wondering if
11 any of you can talk to us about the numbers here, the
12 number of nurses or other staffing titles today
13 compared to years past. What are the trends? Are we
14 losing headcount or is it just that we have a larger
15 patient load? Does anyone have numbers on that?
16 ANN BOVAY: Well, I don't have, I don't
17 have exact numbers but it just seems, you know, what
18 the deal is is that you're looking at ratios that are
19 starting to go backwards not forwards.
20 COUNCIL MEMBER LEVINE: And what about
21 that, so can you compare the ratio today? I think
22 you said it was 20 to 1 which sounds really high.
23 What would that have been 10 years ago or any history
24 on the trend with that?
25

2 ANN BOVAY: Well, 10 years ago it would
3 have been better. It would have been like 1 to 8, 1
4 to you know like that

5 COUNCIL MEMBER LEVINE: My goodness.

6 ANN BOVAY: And the real issue in what
7 I've seen from a Union standpoint, because before I
8 retired, I was the local bargaining unit president
9 for Bellevue as well as I was Judith's predecessor in
10 terms of HHC, New York City Health and Hospitals and
11 the idea of safety is a huge concern. You know, if
12 you have an overcrowded Emergency Room, not even if
13 it's behavioral health but a overcrowded Emergency
14 Room. Everybody in there isn't because one day they
15 decided to go laddi, doddie, dah. They're in crisis
16 so subsequently you need to provide an environment
17 that is going to be as safe as possible for all those
18 individuals and what really struck me the last time I
19 was down there was that stretcher was next to
20 stretcher, next to stretcher. It's the flu season so
21 my background is critical care, mid surge so, you
22 know, my eyes are gonna look in that direction
23 initially but you know, communicable diseases and
24 when a patient comes in, and they're in crisis, they
25 need to have space where they can be on a one to one

2 and be deescalated and if you look at the set-up at
3 Bellevue right now, it needs to be revamped and the
4 fact that 16 people, nurses, BHA's, people that had
5 direct contact with patients didn't have those
6 resources and were hurt and it wasn't little hurts.
7 It was like, you know, something got broken, you
8 know, massive tissue damage, etc.

9 COUNCIL MEMBER LEVINE: That sounds,
10 really sounds terrible and it is related to staffing
11 levels. Do you know, either Ms. Bovay or Nurse
12 Cutcheon how many [Inaudible] members you have at H &
13 H working in behavioral health?

14 ANN BOVAY AND NURSE CUTCHEON: No, not
15 off the top of my head.

16 COUNCIL MEMBER LEVINE: Okay, I think
17 we'd probably be very curious if you can get back to
18 us with that number and particularly if you could
19 compare that to years past. It would be very
20 disturbing if the headcount was dropping at a time
21 when the need is increasing and I would have, and
22 yes, the same question for DC 37.

23 JEANINE THOMAS: Well, one thing that
24 Human Resources tells us is that even if you're gonna
25 hire, it takes about six months to really vet out and

2 find out if the person is qualified. The other thing
3 is, the culture in the hospital with the patients is
4 changing. When the city and everyone decided that
5 they're going to make something important like mental
6 health, then that brings in a whole wave of folks
7 that you never dealt with before so now you have an
8 increase in the population of the patients coming in
9 the hospital and although I've heard that DOH has
10 been trained and they trying to train police, what's
11 happening is H & H for some reason has been left out
12 in the restructuring so we're catching up to
13 something that's probably new in other places but
14 we're dealing with the old stuff so even if you was
15 to look at the statistics, they're not including the
16 new population that is coming in so that's a problem
17 because you have them with a ratio from the past but
18 not to the present and then if they're decreasing
19 beds not according to the need but according to the
20 money and so you have a lot of this going on and we
21 need a fresh look, someone to take a real time fresh
22 look at what's coming in and the staffing levels.
23 Again even if you have psychiatrist and psychologist
24 in [Inaudible] which I love, you still need the floor
25 folks. You have other titles that are

2 therapeutically there to tell the psychiatrist, even
3 if there's two, what's going on but they don't even
4 have time to record, you understand, what's happening
5 with the patient on a daily basis.
6 COUNCIL MEMBER LEVINE: All right.
7 JUDITH CUTCHEON: In addition, the needs
8 of the staffing has increased because security level
9 of the patient has also increased. We get in now,
10 I'm ambulatory, and I get a lot of patients that come
11 in now for the first visit and they're also psych.
12 After you do the assessment, we do have what we call
13 a PHQ9 and they ask individual psychiatric questions,
14 suicidal, or if you're homicidal, those things and
15 you'd be surprised of what the patients are answering
16 and sometimes they'll say, I had chest pains but when
17 you finish the conversation with them, it's all
18 mental health and unrelated to chest pain because
19 they needed to talk and in private hospitals, you
20 know, a lot of them closed, they [Inaudible] so now
21 the need for the nursing staff and [Inaudible] staff
22 and social work and every other staff is also
23 increasing so thank you again.
24 COUNCIL MEMBER LEVINE: Thank you, thank
25 you Chairs.

ANN BOVAY: Just one more, the elephant in the room for me is also the affiliation, the physician, a multi-disciplinary approach. I talked to you about crisis management classes and putting the nursing staff, all levels of nursing staff through it. At Bellevue the physician group in psychiatry is not participating on a level of any substance that shows they're involvement in that and I think that what needs to be looked at further is the affiliations, accountability and responsibility in terms of the delivery of care and I can't speak to you with more fervorance in terms of that. I can't tell you specific instances because of the fact that, you know, their counseling grievance, whatever, but there's been situations where nurses have been, you know, charged with things that weren't true, pushed aside and, you know, to cover up certain things that house staff has been accountable for.

COUNCIL MEMBER LEVINE: Okay, thank you again. Thank you Chairs.

CHAIRPERSON RIVERA: Council Member Holden.

COUNCIL MEMBER HOLDEN: So it sounds like we could actually double the staff and that we need

2 to do that in some of these hospitals. Are you
3 seeing, because you're short on staff, do you see
4 that there, the doctors are prescribing medication
5 instead and sort of warehousing or just, go ahead.
6 I'm sorry.

7 ANN BOVAY: No I don't, it's not so much,
8 what I hear from the nurses in psychiatry, it's not
9 the issue of them ordering too much medications, but
10 they're not necessarily ordering the right
11 medications and not really addressing what the
12 patient's behavioral needs are and the length of stay
13 has diminished significantly. I'll give you an
14 example, somebody's depressed, okay. When they're
15 depressed where they need to be hospitalized, they
16 don't have the energy to carry out a plan that they
17 may have formulated in their brain about doing
18 themselves in. They come to the hospital. They get
19 medication, they get strength but they don't get the
20 right continuance of the therapy necessary that would
21 then not have them thinking on the process, on the
22 pathway to do themselves in so now they're discharged
23 early and then the end result is a very negative.

24 COUNCIL MEMBER HOLDEN: They have the
25 same problem and so

2 ANN BOVAY: And then, or they're
3 successful in terms of taking out what their initial
4 plan of action was so I think part of the deal also
5 is to look at what is the plan of care and how do you
6 sustain that more from a central, central office type
7 of framework. You have, you have these central line
8 bundles so that you don't get central line infections
9 and that comes out of the corporate office, or it
10 comes out of the central agency. Why can't the same
11 be done for behavioral health in regards to that?
12 JEANINE THOMAS: The question you ask is
13 very complicated. From facility to facility you will
14 get a different answer. There are some hospitals
15 that get more money for not medicating so that could
16 drive something but the other, the flip side of that
17 is that there are a lot more injuries to the patients
18 and to the staff. That therapeutic word that we keep
19 using, that is almost non-existent. We really need
20 to, as a city, look at that because if we're just
21 housing patients, then we're not doing really any
22 service and that's what this is becoming. It's
23 becoming an agency that is overwhelmed and so we're
24 just gonna house folk and that's what it's becoming.
25 COUNCIL MEMBER HOLDEN: Thank you.

2 CHAIRPERSON RIVERA: Council Member
3 Reynoso.
4 COUNCIL MEMBER REYNOSO: Thank you. I
5 want to talk about, back to reimbursement and correct
6 me if I'm wrong. This could just be rumors but I was
7 told at one time Medicaid reimbursed for up to 10
8 days for a patient to stay in a hospital and then it
9 went down to 7 and now it's down to 3 but there's a
10 level of stay a patient can have in a public hospital
11 that would be paid for by Medicaid unless the
12 diagnosis changed to something more severe. Is there
13 a, have we seen Medicaid reimburse differently over
14 the last couple of years or the last, anytime. I
15 just want to know where they're intensivising folks
16 to get pushed out of the hospitals earlier than they
17 should because of the reimbursement?
18 ANN BOVAY: On some levels that's true
19 but when you're looking at behavioral health, they
20 definitely increased the number of days. I can't
21 tell you what they are but in terms of case managers
22 when they talk, it's looking at a decrease in the
23 length of stay.
24 COUNCIL MEMBER REYNOSO: Encouraging it
25 because Medicaid won't pay it anymore?

2 ANN BOVAY: In terms of cost of daily
3 coverage, yes.
4 COUNCIL MEMBER REYNOSO: So, all right,
5 so there's, the value of keeping a patient is simply,
6 it's good for the patient but it's, it ends up having
7 health [Inaudible] for the [Inaudible].
8 ANN BOVAY: In all the hospital closures
9 that we've had around Bellevue, Beth Israel, St.
10 Vincent's, Cabrini, all of those, the first service
11 to go was psych, the first service as well as the
12 specialty services like cardiovascular, etc. but the
13 service to go first was behavioral health.
14 JUDITH CUTCHEON: And it's not just
15 Medicaid, it's other insurance
16 COUNCIL MEMBER REYNOSO: Yes.
17 JUDITH CUTCHEON: Companies also. Mental
18 health funding is the least paid for mental health
19 and I believe personally, from personal experience
20 that I'm sharing, I lost a daughter to committing
21 suicide and there was a lack of funding on the
22 individual and resources which two people are gone
23 now and it's the same cycle. It's over and over.
24 It's no funding. We can get you in, but you got no
25 money. Okay, you gotta go, then kick you out and

2 then mental health. It just, it varies, [Inaudible]
3 again and we get all of these different crisis and
4 suicides, young kids, you know. It's really, you
5 know, we have to be very vigilant on this mental
6 health issue that we have in our five boroughs.
7 COUNCIL MEMBER REYNOSO: In your
8 professional experience, do you know of any way that
9 we can intensify, to take private hospitals to take
10 on more beds or insurance companies to take
11 [Inaudible] in terms of service that's not related to
12 city funding? We all need to pay for it. I'm not
13 saying we don't want to. I'm just saying are their
14 alternatives to expanding services across the city of
15 New York, outside tax dollars.
16 ANN BOVAY: Well, I think that, I think
17 that comes through also the state in terms of looking
18 at state reimbursement through Medicare and Medicaid
19 and I think it also goes back to developing standards
20 of care that are consistent, that can be applied to
21 that reimbursement. You know, everybody should be
22 doing the same thing. I, when they brought up the
23 central line infection rate, it's almost down to
24 zero. It should be zero but it's almost down to zero
25 so something should be also developed in terms of a

2 consortium to look at the handling of patients with
3 behavioral health. It's not a cookie cutter type of
4 deal but a framework that you can develop, a quick
5 plan of care for those individuals and reimburse them
6 for receiving their care.

7 JEANINE THOMAS: There was a time, I
8 think it was about two years ago in the Bronx where
9 CPHS started to have talks with the non-for-profit
10 mental health folks in the area and they became very
11 involved so sometimes when you outreach to and you
12 have those kinds of forums and you pull them in and
13 they begin to understand how they can get involved so
14 you can collaborate, that brings more non-for-profit
15 people in. The reason why they stay out is they
16 don't know how to get in so when you have that
17 outreach and you bring them into a forum, they become
18 involved and that also helps with our dilemma.

19 CHAIRPERSON RIVERA: Any other questions?

20 ANN BOVAY: I just wanted to say I'm also
21 here to represent [Inaudible] because I'm treasurer
22 of that organization as well as commission on the
23 public health system, [Inaudible] director.

24 CHAIRPERSON RIVERA: Thank you. Thank
25 you ladies. Thank you so much. Any other, oh, we

2 have one more person to testify. Jennifer Rento
3 Kentun [phonetic].
4 JENNIFER: Hello, my name is Jennifer
5 Rento Kentun. I'm a registered nurse here at
6 Metropolitan Hospital and working in occupational
7 health but prior to that I used to work with the ACT
8 team where I used to go visit patients who are
9 persistently mentally ill in their homes and in the
10 community and prior to that I worked in an inpatient
11 unit and we used to have a triage unit where we would
12 see patients with substance abuse and with mental
13 health issues and then try to [Inaudible] ready like
14 two weeks and then refer to the outpatient services.
15 My main reason for wanting to say something is
16 because I think we need more outpatient services and
17 the outpatient services that we have here at
18 Metropolitan Hospital and I'm not sure, needless to
19 say, [Inaudible] programs which I think were helpful
20 and the patients, many people, you know, a lot of our
21 mentally ill patients are extremely vulnerable and
22 they need support and so I'm wondering, you know,
23 what can we do in terms of outpatient services. Can
24 we, I know we have the [Inaudible] clinic but I mean,
25 they just come in there like once a month or is it

2 two weeks or something. I don't think that's
3 adequate and I know talking about reimbursement but I
4 think if we look at how we also submit our claims, we
5 can [Inaudible] to submit claims in a timely matter
6 then at least we could get some sort of reimbursement
7 but we also need to [Inaudible] into different
8 services to have people who know how to bill and so
9 forth stay on top of it so we can get some kind of
10 reimbursements. I know money is a big thing for it
11 [Inaudible] outpatient services. We do not find help
12 and the patients know that we have all these
13 different drugs out there, we also need probably more
14 training on not just people who work in mental, in
15 behavioral health but in other areas too [Inaudible]
16 for how to handle patients in here, like [Inaudible]
17 behavioral health conditions.
18 CHAIRPERSON RIVERA: And you're a
19 registered nurse?
20 JENNIFER: Yes, I'm a registered nurse
21 here at Metropolitan Hospital. I'm no longer working
22 with the behavioral health patients. They are really
23 not my patients but I have a passion for patients
24 [Inaudible] and stuff like that so I'm here
25

2 [Inaudible] and handle the services necessary and
3 required.
4 CHAIRPERSON RIVERA: Thank you so much.
5 Are there any other members of the public who wish to
6 testify today? Yes? Just stand right there and use
7 your microphone and introduce yourself.
8 DR. DAVIDMAN: My name is Leonard
9 Davidman. I'm a psychologist. I actually work here
10 at Metropolitan Hospital. I've been here for 41
11 years and I've been working at HHC for almost 48
12 years. I'm also the president of the Psychologists'
13 Union here for the City, DC37. I represent all of
14 the public hospitals, NYPD, the Department of
15 Corrections, family court, criminal court and I work
16 here full time also so just a few things. There's a
17 question I've had, reimbursement, to add
18 clarification to the City Council Members about
19 reimbursement which I think you can't help at this
20 point but I will tell you what's going on. There's a
21 thing called a parity law which means that we treat
22 mental health the same way we treat physical health
23 and recently the U. S. State Controller sued I think,
24 five different insurance companies who were breaking
25 that law. They didn't treat them properly. I myself

2 look at denials. There are, if you, as you know, if
3 Medicaid insurance, they count every day that a
4 patient is in the hospital. They will justify the
5 admission or they'll deny admission or they'll deny
6 continued stay. I look at these referrals, these
7 denials and sometimes I even write the appeals. I
8 just, I'm doing one right now where, you talk about
9 suicide and about the treatment, so we just had a kid
10 come in who was depressed, catatonic, not eating for
11 days and we began to stabilize her in the hospital.
12 We needed to use certain kind of medications to
13 stabilize and then she said she was fine. The
14 insurance says okay, we're no longer paying. We
15 needed to stipulate a special readjustment of an
16 injectable medication, which we just got but we have
17 to now spend time in writing letters, writing reports
18 instead the new patient can write things to justify
19 the child's stay because of the insurance person on
20 the computer checklist and presented fine will give
21 you a day or so but there is a big pressure to
22 discharge and not being paid so the reimbursement is
23 not about City Council or the Mayor. That's really a
24 state as well as federal of these rules and I'm
25 [Inaudible] at the state's [Inaudible] insurance

2 coverage and they're getting a lot of money back and
3 actually I think if you read them you might see that
4 Dr. Katz also sued, I think, one insurance company
5 and got the reimbursement. This was for medical and
6 also not being treated properly in terms of how the
7 reimburse was justified and so this information that
8 you need to know it's not about the amount of money
9 but the fact insurance is trying very hard not to pay
10 anyone and if you don't find it, they're not gonna
11 pay so they don't really care so that's [Inaudible]
12 of that. Number two, I represent union right
13 psychologists and Rikers Island was behind a lot of
14 psychologists who really provide them with
15 [Inaudible], the HHC system who hired them. They
16 went through [Inaudible] to avoid unionization of
17 psychologists. They changed their title so they seem
18 managerial and it's a way just to avoid civil service
19 rules and no one is addressing that. I was shocked.
20 I kept saying where are my numbers, where are, Rikers
21 has psychologists, where are they? I got a nice
22 large group of psychologists in which [Inaudible]
23 care but they're not unionized and they're not,
24 they're not, they should be unionized. They should
25 be city workers, not workers just for [Inaudible].

2 Also, just as importantly, every hospital is very
3 different has these psychologist and I think people
4 look at them, some hospitals have many psychologists,
5 like East Harlem, Bellevue and some have very few and
6 these are a better group of psychologists in terms of
7 numbers. The Council Member who left, he is a, like
8 he said he went to study mental health counseling.
9 Who was it?
10 CHAIRPERSON RIVERA: Yeah.
11 DR. DAVIDMAN: Now I respect [Inaudible].
12 I know him. At the same time, they are not trained
13 at the same level as a [Inaudible] psychologist and I
14 know that we have them here at Metropolitan and
15 they're good people but there's a need to require
16 more. There's [Inaudible] expense. They put
17 licensed psychologists who are trained at the highest
18 levels and the [Inaudible] we've already also and I
19 don't want to have a war between the mental health
20 counselors. They do a good job but I, you have to be
21 a higher level psychologist also. This code, this
22 NYPD program of having code, of people going out with
23 the cops, take your mental health cases, that wasn't
24 working, that actually wasn't working at the start
25 and it wasn't working that well. People left because

2 the people, members who were psychology supervisors
3 were trying to supervise poorly trained mental health
4 people and they could not work with the cops and so
5 those things fell apart. I'm not sure what happened
6 to them but you might know more than I do about that
7 situation but that needs to be looked into because of
8 what's going on, these situations.

9 CHAIRPERSON RIVERA: Thank you so much.
10 Thank you for 48 years of service to Health &
11 Hospitals and for all of your valued testimony. Do
12 you have any questions for him?

13 CHAIRPERSON AYALA: I have one. I, I
14 wonder what your medical opinion is on, we're seeing
15 more and more volunteer hospitals shutting down
16 psychiatric beds, the impact on a person's mental
17 health after having to leave their own community,
18 like what do you, what do you, what is your medical
19 opinion of that?

20 DR. DAVIDMAN: I'm not sure what you
21 mean. What do you mean?

22 CHAIRPERSON AYALA: We have certain
23 hospitals that are volunteer hospitals, right, then
24 the HHC [Inaudible] that are shutting down beds and
25 so [Inaudible] Harlem and now my hospital doesn't

2 have any beds because they lost and shut them down
3 and I have to go to Inwood. What is the effect on
4 the patient to have to leave my community and my
5 support system?
6 DR. DAVIDMAN: Well, I do know that here
7 at Metropolitan, the community loves us and I know
8 that at East Harlem, they love to come here.
9 [Inaudible] The patients from this community feel
10 they are taken care of here, they are cared for.
11 They feel very much at home and I think when you
12 leave the community, you feel a little, I won't say
13 it's traumatic but it borders on trauma because you
14 want to feel treatment in an environment that you
15 feel respected, loved, cared for and so when you have
16 [Inaudible], I'm sure the workers are good but it's
17 not the same as being treated in your community so
18 how does it affect them? I believe it's a great
19 transition. It's about the most money. It's how
20 much money they can make along that so if they close
21 the beds, what happens if it's not full everyday so
22 they're closing but it does affect. I can't give you
23 a number or a statistic but just my experience that
24 they feel at home if they're at their own hospital.
25

2 CHAIRPERSON RIVERA: Thank you and just
3 be sure to fill one of these out so we get your name
4 and we have you on record as contributing your
5 testimony to today's hearing.

6 DR. DAVIDMAN: I just want to say one
7 other thing is that I've been working for
8 Metropolitan here for a long time and really the
9 staff here, first the doctors do a great job. I read
10 charts of these doctors. These very violent major
11 cases of chronic illness, they're medicated properly
12 and the doctors work their behinds off to make sure
13 they're safe so as people, they're not, they are not
14 given enough credit. They do a great job and the
15 nurses work very hard and the staff, they love those
16 kids and they love those adults. {Inaudible] anyway.

17 CHAIRPERSON RIVERA: Thank you.

18 DR. DAVIDMAN: The pleasure's mine. I
19 appreciate it.

20 CHAIRPERSON RIVERA: So we are, I just
21 want to again thank everyone for being here today.
22 This was one of the many reasons that we brought this
23 hearing out to one of the hospitals that had the
24 nurses and the doctors and potentially patients to
25 come and testify, provide comments on their

2 experiences and even their recommendations. It is
3 through your own day to day responsibilities and what
4 you've seen over decades that we hope will improve
5 the system overall and yet a lot of it is how to,
6 what happens on the state and federal level. That's
7 absolutely true but we here at the City Council want
8 to be clear in that we support Health & Hospitals as
9 a system and that we plan to hold Health & Hospitals
10 as well as voluntary hospitals accountable and we
11 will always be demanding transparency and so whether
12 it comes to, you know, we want to consider all
13 perspectives and I'm so glad there was a diverse
14 panel that showed up today and so we know that
15 Dr. Katz is committed to improving the system and
16 whether it's just something as simple as billing or
17 coding, staffing, training, but also looking at how
18 we can all work together to improve the formula and
19 how dollars are distributed, looking at charity
20 dollars or indigent care pool and how certain
21 hospitals are stepping up specifically when it comes
22 to psychiatric care and other hospitals are not and
23 so we're here at Metropolitan because this is one of
24 the 11 acute facilities. It is in the wonderful
25

2 neighborhood of El Barrio represented by Council
3 Member Ayala
4 [applause]
5 CHAIRPERSON RIVERA: And we want to
6 [Inaudible] and she and specifically when it comes to
7 mental health and some of the statistics that come
8 out of this area specifically, us being the only two
9 Latinos in the Council and the rate of suicide among
10 this specific population and that is all a part of
11 being well and we hope that with our help and with
12 your help and everything that we're doing as a
13 Council, that we really will see a New York City that
14 can thrive so thank you so much everyone.
15 [applause]
16 CHAIRPERSON RIVERA: And with that we
17 will close the hearing. Thank you so much. [gavel]
18
19 **[TRANSCRIPTION NOTE: Audio is from an off-site**
20 **hearing, has background noise and is difficult to**
21 **hear the speakers as well as someone is frequently**
22 **coughing right into the microphone, so much of this**
23 **document was transcribed from the video. There is no**
24 **video available from page 97 (audio 1:58:30) to the**
25 **end.]**

C E R T I F I C A T E

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

Date ______July 23, 2018______