NYC HEALTH + HOSPITALS

New York City Council Hearing

Oversight:

Access to Specialty Care at

New York City Health + Hospitals

Committee on Hospitals

Mitchell Katz, M.D.

President and Chief Executive Officer

NYC Health + Hospitals

February 25, 2019

Good afternoon Chairwoman Rivera, and members of the Hospitals Committee. I am Mitchell Katz, M.D., President and Chief Executive Officer of the NYC Health + Hospitals ("Health + Hospitals"). Thank you for the opportunity to share Health + Hospitals progress in implementing one of our top priorities – improving access to needed specialty care. Joining me here today is Dr. Dave Chokshi, Health + Hospitals Chief Population Health Officer.

As you know, I am a primary care doctor and I am a strong believer in the value of primary care for keeping patients healthy. We've made great progress on access to primary care in recent months and patients can now see a primary care provider in our system within one to two weeks (some patients may wait longer if they wish to see a particular doctor in a particular clinic).

But as much as I believe in primary care, at times my patients need specialty care—something beyond what a primary care doctor can do. They may have severe congestive heart failure or a broken bone.

In serious cases, Health + Hospitals can ensure immediate access to specialty care. If you, for example, have an acute loss of vision and come to see me, I will get you to an ophthalmologist today. And the quality of the clinical care in our system is as high as any provider in the city. But when the need is less, but not an emergency—a patient with a severely arthritic joint, a patient with persistent gastrointestinal reflux, the waiting times can be much longer.

Part of the challenge is that reimbursement for uninsured persons needing outpatient specialty care is very limited and therefore a person without insurance in New York has few options for where they can receive specialty care at an affordable price. This is different than primary care and inpatient specialty care.

Federally Qualified Health Centers (FQHC) receive enhanced Medicaid payments and some federal grants to help them provide primary care to uninsured patients. As a result, FQHCs are able to offer those services broadly and uninsured patients can find primary care outside of Health + Hospitals. Similarly, for inpatient specialty care, private hospitals can receive revenue from the state and federal governments for caring for the uninsured. And so an uninsured patient coming in through the ED or needing inpatient care can often get seen at a private hospital.

But for outpatient specialty care, there is no state or federal revenue stream for health care providers. As a result, for a low income, uninsured person, it is very very difficult to get an outpatient specialty appointment at a private health care provider. And one of the reasons I love public health systems and that I am so proud to work at Health + Hospitals, is that we offer our outstanding specialty care to all New Yorkers, regardless of whether they have insurance. We are very proud of that mission and the care we provide, but it does pose specialty access challenges that are unique to Health + Hospitals.

Like many things in a large system like ours, there is a lot of variation in the wait times for different specialties at different hospitals. Again, while any urgent and certainly any emergent need for a specialty care is met right away, if you were a new patient trying to make an appointment for a subspecialty at one of our hospitals – say a consult with a neurologist or a rheumatologist – the wait could be several weeks. The balance we need to strike is how do we provide a good patient experience and connect people to the care they need, while making sure we're not overloading our specialty clinics with patients who could be seen in primary care.

So how is Health + Hospitals working to strike that balance and get patients the right care at the right time in the right place? First, we're using technology to speed up access to needed specialty care. Our expanding eConsult system lets primary care doctors like me send an electronic referral directly to a specialty clinic. I can include all the necessary clinical information, any scans or other images, and any information a specialist needs to provide an initial consult. My eConsult will then be reviewed by a clinical expert right away. If the specialist thinks I can handled the patient in primary care, they will share their guidance back with me, giving me suggestions such as a change of medicine If the specialist believes the patient needs to be seen, the patient will be contacted with an appointment.

Today, eConsult is live in over 100 clinics across 10 facilities, including adult medical and surgical subspecialties, behavioral health, and pediatric subspecialties.[1] Nearly 8,000 referrals per month are managed by eConsult clinics, which is up from 2,300 per month in 29 clinics in January 2018. And our average review and respond time is under three days. For a set of 14 specialty clinics using eConsult, for over a year, we saw a 23% reduction in overall wait time for new patient visits.

Second, we need to continue to improve our scheduling systems and our referral practices to reduce no shows and limit overbooking. We are working with clinics across our system, our referral offices, and our appointment call center to standardize our scheduling templates and referral practices. Something as simple as making sure appointments slots are the right length can have a major impact

[1] Bellevue, Coney Island, Harlem, Kings County, Jacobi, Lincoln, Woodhull, Metropolitan, North Central Bronx, and Elmhurst.

on how long people wait to get in for an appointment. Similarly, making sure our referral offices, our emergency departments, and our call center can effectively schedule patients is critical. When a person leaves our emergency department with an appointment for a follow up visit, it needs to be a real, dedicated appointment, not just a direction to seek a walk in visit. Rolling out our unified EPIC electronic health record and referral and scheduling processes will be a big help in reducing no shows and wait times.

Third, we need to invest in new clinical services and providers that will help us meet demand for specialty care. In recent months we have approved business plans to invest in HIV care, gastrointestinal care, cardiac care, and several other areas. If we can address demand and reduce wait times by making smart investments, I want to do that.

Finally, while I have focused a lot on ways we are looking to improve access to specialty care, I don't want to lose sight of the amazing specialty care we – and often we alone – provide to hundreds of thousands of New Yorkers each year. Health + Hospitals has an enormous range of specialty clinics that is unmatched across any public system in the country. For instance, at Metropolitan Hospital, we offer some gender affirming surgeries to transgender and non-conforming patients – making us the only public hospital in the nation that provides those services. From our unmatched behavioral health services, to infectious diseases, to care for the disabled or other underrepresented populations, our specialty care services are one of the many things that make me so proud to work at Health + Hospitals.

Thank you again for having me today, and Dr. Chokshi and I look forward to your questions.

Health + Hospitals' Approach to Specialty Care

Below are some of the specialty care services that are offered at Health + Hospitals:

HIV Services: New York City has been a leader in fighting the HIV/AIDS epidemic for decades but in recent years some services at Health + Hospitals were shrinking – losing patients and missing a revenue opportunity for our system. NYC Health + Hospitals/Jacobi recently announced the Health & Empowerment Center, which is an expansion of a multi-service clinic that will expand access to comprehensive, state-of-the-art HIV treatment, education, and prevention services. With expanded staff and a one-stop service model to offer on-site nutrition counseling, mental health services, and more, the center will be able to serve an additional 100 patients annually, offer same-day appointments, and give the city's public option health plan, MetroPlus, an opportunity to enroll more patients in its specially designed plan for patients with HIV. NYC Health + Hospitals is investing $1.1 million annually to cover additional staffing, including an additional full-time HIV specialist and two new nurses. The center is part of NYC Health + Hospitals' comprehensive, multi-year redesign to build a competitive, sustainable organization that will continue to offer high-quality and accessible health care to the people of New York City.

Child & Adolescent Behavioral Health Services: Within the system, Bellevue, Elmhurst, Kings County, and Metropolitan hospitals provide the full continuum of acute and routine mental health services for children and adolescents, including a combined 134 inpatient psychiatric beds, and robust outpatient behavioral health services for youths, including: psychiatric

evaluation, medication, individual, group, and family therapy. Follow-up mental health appointments are provided, as needed. Other specialty services included, but not limited to are:

- **Children's Comprehensive Psychiatric Emergency Program (CPEP)**: Bellevue Hospital has the only dedicated Children's CPEP in the State, which includes comprehensive psychiatric assessment and brief stabilization with six child and adolescent extended observation beds and a very busy Interim Crisis Clinic.
- **Partial Hospitalization Programs**: At Elmhurst and Bellevue, patients receive mental health services five days per week for six weeks while attending hospital-based schools.
- **Home-Based Crisis Intervention Units**: At Elmhurst and Bellevue, patients at risk of inpatient hospitalization can be followed at home by staff 2-3 times per week for six to twelve weeks.
- **"First Episode" Psychosis Program**: Kings County has a combined adolescent and young adult inpatient unit to address the needs of youths who present with their "first episode" of psychosis. They are often at risk for dangerous behavior, including suicide attempts.
- **Mobile Crisis Units**: At Elmhurst, Bellevue, Kings County, and Lincoln if hospital staff cannot contact the patient; a mobile crisis unit is sent to their home for follow-up.

Trauma-informed care: Over the next year, Health + Hospitals in collaboration with NYC Department of Health and Mental Hygiene, will model and begin implementation of a trauma-informed care system in several of our hospitals' obstetrics department, as implemented by Trauma

Transformed from the Bay Area in California. The goal of the program is to build the capacity of clinical providers to recognize and mitigate the impact of organizational trauma, implicit and explicit bias, and gender oppression on birth outcomes for women of color. Principles of a trauma-informed system include: 1) understanding trauma and stress; 2) safety and stability; 3) cultural humility and responsiveness; 4) compassion and dependability; 5) collaboration and empowerment; and 6) resiliency and recovery. Trauma can have a long-lasting and broad impact on lives that can create a feeling of hopelessness.

Access to care for disabled individuals: Health + Hospitals has worked with the Independence Care System (ICS) Women's Health Program to conduct an environmental review to assess issues related to disabled individuals' ability to obtain services in our facilities. Their recommendations included: 1) review of and modifications to operations policies and practices; 2) establishment of essential patient supports; 3) disability sensitivity and awareness training for clinical and non-clinical staff; 4) coordination of pre and post onsite care for ICS members referred to the facility for Women's Health Services; and 5) equipment that will facilitate health care for women with disabilities.

In 2014, the City Council provided $2.5 million in capital funding to update four facilities – Morrisania, Sydenham, Cumberland, and Woodhull. The projects are in various stages of implementation. The programmatic components are now being implemented at Lincoln, and Gouverneur. In FY19, the City Council awarded funding of $125,000 to ICS to support the Women's Health Access program at ICS to continue its work with Health + Hospital to increase access to accessible/disability competent care to women

with physical disabilities. We look forward to collaborating with ICS on this important work.

The Governor's Executive Budget:
Additional funding needed to be all-inclusive for every New Yorker

At the Commission on the Public's Health System (CPHS), we believe that when you show us your budget, we can tell what you value. The FY2019 Executive Budget presented by Governor Andrew M. Cuomo puts $74 billion in healthcare spending, which is a spending increase of 4.5 percent from last year's state budget. However, the initial budget falls short on opportunities to fix inequities in health care rights and options to accessing health care. The decline in expected tax revenue and a threatening environment in Washington, D.C., has resulted in reducing the initial spending, cuts and changes in the direction of boosting Medicaid and funding safety-net facilities. It all adds up to a $550 million dollar cut reflected in the Governor's 30-day amendments to the language in the initial executive budget.

We find important initiatives in the executive budget protect women and other marginalized communities. They include protecting access to safe, accessible, and competent reproductive health care; $4 million to establish a Maternal Mortality Review Board; creation of an expert panel on postpartum care to develop recommendations targeting the time immediately after birth. $4 million to expand the Community Health Worker programs in key communities; codifying aspects of the Affordable Care Act, such as the state health insurance marketplace and prohibition on insurers discriminating against people with pre-existing conditions in state law and legalization of marijuana legal for use by adults, and to regulate and tax its production and sale.

CPHS review of the Governors Executive Budget reveals that New York State did not again take the opportunity to fix some other historical healthcare inequities that affect low-income immigrant and communities of color.

Adequate Distribution of Funds

There was no provision for addressing the unfair distribution of funds for the hospitals that care for people who are low-income and uninsured, many of whom are immigrants. New York State's formula continues to use some of the funding, because of the transition collar, to pay for bad debt.

For years, claiming Bad Debt allowed several voluntary hospitals to game the system in their reporting of actual care to the uninsured and people on Medicaid. Bad debt is a charge for care that has been uncollectable by the hospital. In 2012, when it was determined that this needed to change with anticipated federal guidance (85% of funds), a political deal was made whereby a transition period, initially for three years, was allowed and a collar was in place to limit a hospital's exposure (around 15% of the funds) to potential losses through the payment changes. Since 2012, the Transition Collar has been extended twice. The New York State 2018 budget only extended this transition period by one year.

Last year, the state convened an Indigent Care Pool (ICP) working group to identify a new way to distribute funds to safety net hospitals who provide most of the low or no-cost services to the uninsured. Despite a requirement to issue an ICP report by December 1, 2018, the state just recently last month released the report. The report undervalues and overrates some key points of discussion and deliberation. This report had minimal to no influence in the Governor and Budget Director's decisions. The Transition Collar was not been addressed in this initial budget. There was, though, some language incorporated in the 30-day amendment related to how ICP (charity

care) funds on allocation. Nevertheless, the Greater New York Hospital Association (GNYHA) and Healthcare Association of New York (HANYS) have been able to politically influence the funding of large hospitals and academic medical centers, leaving the safety net hospitals (even if these safety net hospitals are their members) to advocate for themselves.

The Governor's 30-day budget amendment did propose several changes to the language in the initial budget. We need to ensure protections for our public hospitals and voluntary hospitals that are safety-net providers. These safety net agencies should not lose funding due to the lobbying efforts from Greater New York Hospital Association. These political deals have not benefited the population at large especially those uninsured, underinsured and people on Medicaid.

The 30-day amendment proposals included:

- A reduction in the voluntary hospital pool by $275 million. We need to ensure that community hospitals that serve high number of people that are uninsured or on Medicaid are not the ones hurt but the reductions. These funds should not be directed towards the general operating funds.

- A recommendation advocated by New York State Nurses Association was partially adopted in terms of indigent care program (ICP). Certain hospitals with margins greater than 2.98% and $68 million would get limited funding for the ICP (Charity Care) pool. Hundreds of millions and more has been spent from this pool and very little can be traced to care for an uninsured or Medicaid patient. CPHS supports limiting this funding to these hospitals with significant profits margins. Subsequently, these funds should be re-invested into those facilities that have provided disparate amount of care.

- An across-the-board cut in Medicaid reimbursement, which can include alternative approaches to achieve the reduction. The initial budget proposed an increase in Medicaid payment but has now been rescinded. Medicaid payments to hospitals and other providers play an important role in these providers' finances, which can affect low-income communities' access to care. Increases in base rates have lagged behind increases in costs, especially for true safety-net providers. It must be ensured that there is no impact on state general fund or Medicaid global cap.

In Article VII of proposed amendments that authorize a Medicaid across the board reduction, language stated, "that an alternative method may be considered at the discretion of the commissioner of health and the director of the budget based upon consultation with the health care industry". This is a concern. There is a New York State hospital code that defines agencies, public, urban or voluntary. which provide critical services. Although this is detached from the ICP Funding Pool, it should provide the direction for the ICP method and alternative approaches in achieving costs in the 30 -day amendments.

Source:
https://www.budget.ny.gov/pubs/archive/fy20/exec/30day/hmh-artvii-narrative.pdf
https://www.budget.ny.gov/pubs/archive/fy20/exec/30day/hmh-artvii-newpart-dd.pdf
https://www.crainsnewyork.com/health-care/cuomo-walks-back-550-million-promised-health-care-funding

Recommendations for Action

The New York State Legislature (Senate and the Assembly) need to adopt the legislative changes proposed in language put forward by the NYC Health + Hospitals and NYSNA coalition. These efforts reflect endorsing one house budget bills so that it can be subject of negotiations with the Governor before adopting the final state budget. The following actions are critical to be included in the one-house bills and/or to be adopted in free-standing legislation are:

- Eliminate the ICP Transition Collar;
- Increase Medicaid reimbursement rates for safety net and/or at risk/needy hospitals;
- Expand existing programs for financially distressed hospitals to ensure no harm to safety net
- or at risk/needy hospitals;
- Leverage public hospitals' access to federal DSH;
- Protect the State from larger Federal cuts;
- Ensure no impact on state general fund or Medicaid global cap; and
- Provide fairer distribution of hospital funding based on need, both upstate and downstate.

Healthcare Coverage to Immigrants Statewide

CPHS supports the sentiments of our colleagues at the New York Immigration Coalition. The Executive Budget failed to address the pressing healthcare coverage needs of immigrants across New York State adequately. Despite the more than 400,000 individuals who are excluded from health insurance coverage because of their immigration status, the Governor's Budget does not include funding to expand New York State's Essential Plan to all New Yorkers.

New York State of Health Marketplace has been a big success in New York State. However, there are still New Yorkers without insurance or struggling to afford the private insurance. Like Qualified Health Plans, the Essential Plan covers all of the ten Essential Health Benefits, including emergency services, inpatient hospitalization, primary care, urgent care, sick visits, lab work, radiology, reproductive health care and more. Those who qualify for the Essential Plan will pay a premium of either $0 or $20.

Recommendations for Action

- Advocate for the allocation of $532 million to expand New York State's Essential Plan to all New Yorkers.

Source:
https://www.coverage4all.info/

Other Issues

- There is a reduction of $27 million of certain public health funding for New York City. This presents with a 16% reduction in funding. This will impact matching funds from City Council in Article XI for public health programs and initiatives. Relatively new public health efforts, e.g., Access Health NYC (AHNYC) Initiative are at risk. AHNYC aims to build the capacity of community-based organizations to conduct outreach and education on rights and options to coverage and care. This is a healthcare initiative that was funded by City Council to fill the gap left by the State. In addition, New York County seems to suffer the biggest cut in funding. This cut has been proposed in past Executive budgets. This year there is a higher percentage reduction. The New York State legislature has fought successfully to stop it in past budget negotiations.

- The initial budget proposed $300 million for the second phase of the Statewide Health Care Facility Transformation. The program would support capital projects, debt retirement and activities that support mergers or acquisitions. Many studies show that mergers and consolidations have not reduce costs nor improve access and quality of care, especially for low-income New Yorkers. The 30-day amendments authorize the funds to go to housing services. Housing is extremely important but we need to watch closely how this is implemented with outcomes on communities evaluated. These funds need to be utilized appropriately. Most hospital closings have ended in vacant lots or luxury housing.

- This Executive budget includes a reduction to the Consumer Directed Personal Assistance Program. Several advocates for people with disabilities say the state's plan would greatly hinder the state's entire self-directed care model. The goal of the program is to allow people to stay in their homes.

- This Executive Budget does not include a universal, single-payer health care proposal like the NY Health Act. This has been the official position of the NYS Assembly having passed it four years in a row with overwhelming support. A majority of members of the current New State Senate have expressed support for this legislation. It has growing popular support statewide, just as support for Medicare for All has been rapidly rising nationally. Instead the Governor proposed the creation of a Commission for Universal Access to Health Care comprised of "health policy and insurance experts to develop options for achieving universal access to high-quality, affordable health care in New York" by December 1, 2019. A survey delays action. CPHS strongly supports the New York Health Act (A.5248, S.3577) in the 2019 Legislative session. It is the only plan which will provide health care services for All New York residents.

  In New York City there is a tale of two cities. Our health care system comprised of public and private facilities results in a significant difference in access to quality care. Race/ethnicity and insurance status are closely linked. This means that timely access to care is limited to those patients who are publicly insured or uninsured.

  While the current Federal administration is not friendly to providing waivers to states pursuing single-payer plans, the New York Health Act includes provisions for Implementation even in the absence of Federal waivers. This plan will serve as a "wrap-round" to current programs. If the ACA continues to be attacked, New York can guarantee healthcare to all residents through a state-funded program.

  We do recognized that our union allies have expressed legitimate concerns for their members regarding passage of the legislation. Labor and community will work together to address concerns and impact.

Recommendations for Action

Finally, some of us remember when the former State Medicaid Director stated that New York must "make health care a team sport". The problem is that we either not selected on the team or considered our value to be on the team. Therefore, marginalized communities and the community-based organizations that work with them must advocate and fight to ensure the right

to be part of the decisions around the design, distribution, and delivery of health care programs and services. We cannot run the risk of exacerbating existing health disparities between rich and poor, and white and minority New Yorkers. We need to advocate for changes to the status quo.

Source:
file:///C:/Users/CPHS/AppData/Local/Packages/Microsoft.MicrosoftEdge_8wekyb3d8bbwe/TempState/Downloads/Assembly%20W&M%202019%20budget%20yellowbook%20(1).pdf
https://www.budget.ny.gov/pubs/archive/fy20/exec/fy20bills.html#amends.

For more information, please contact Anthony Feliciano, Commission on the Public's Health System Director, C/o WeWork; 110 Wall Street Rm 4-006: New York, NY 10005; Work:646-690-9089; Cell: 646-325-5317; afeliciano@cphsnyc.org

Respectfully submitted by:

Anne Bove, RN

Anne Bove, RN

CID-NY

Manhattan
841 Broadway
Suite 301
New York, NY 10003
212/674-2300 Tel
212/254-5953 Fax
646/350-2681 VP

Queens
80-02 Kew Gardens Rd
Suite 107
Kew Gardens, NY 11415
646/442-1520 Tel
718/886-0428 Fax
866/948-1064 VP

www.CIDNY.org

Center for Independence of the Disabled, NY

Testimony to the New York City Council Committee on Hospitals

Oversight – Access to Specialty Care at NYC's Health + Hospitals

February 25, 2019

Testimony By:
Heidi Siegfried, Esq.
Director of Health Policy
Center for Independence of the Disabled

This testimony is submitted on behalf of Center for Independence of the Disabled, New York (CIDNY), a non-profit organization founded in 1978. CIDNY's goal is to ensure full integration, independence and equal opportunity for all people with disabilities by removing barriers to full participation in the community. CIDNY helps consumers understand, enroll in and use private and public health programs and access the care they need. We appreciate the opportunity to share with you our thoughts about access to specialty care at NYC's Health + Hospitals.

We have not received any particular complaints about access to specialty care at NYC's Health + Hospitals so what I would like to do is focus this testimony in a more general way on what ***access*** to specialty care means for people with disabilities and why it is important

According to the American Community Survey 11.5% of New Yorkers have a disability with 2.1% having a visual disability, 2.7% having a hearing disability, 6.7% having an ambulatory disability, 4.6% having a cognitive disability, 2.7% having a self-care disability, and 5.4% having an independent living disability.

The HHS – Advisory Committee on Minority Health said in July 2011 that "By every measure, persons with disabilities disproportionately and inequitable experience morbidity and mortality associated with unmet health care needs in every sphere." Disability has been recognized as a bona fide disparities population. People with disabilities are more likely to experience difficulties or delays in getting the health care they need and are more likely to not have had an annual dental visit not have had a mammogram in the past 2 years and not have had a pap test within the past 3 years

A complex interaction of factors influence health status and health outcomes for people with disabilities, These include the limited enforcement of the nondiscrimination, accessibility, accommodation, policy modification, and communication that are required by the Americans with Disabilities Act and the lack of provider education and training , the lack of disability literacy, stigma and stereotypes.

People with disabilities have difficulty finding providers with offices and facilities that are accessible and that have accessible diagnostic and medical equipment. They also have difficulty finding providers that understand their responsibilities under the Americans with Disabilities Act to accommodate any disabilities they might have. Program Standards and Requirements for health care provider accessibility for people with disabilities and people with limited ability to speak or understand English and for cultural competence should be robust and should require training for providers.

Health providers need to do a better job of being responsible for the both physical and programmatic access to their services. Practically speaking, physical access means if parking is provided, wheelchair accessible parking is available, a level entrance to the facility, an accessible path within the facility, an elevator if offices and services are provided above the first floor, wheelchair accessible restrooms, signage for accessibility features, and tactile signage. Providers are responsible for providing medical equipment that ensures an individual with a disability can receive the same health services. Examples include, but are not limited to adjustable exam tables, accessible weight scales.

Programmatic Access means that the policies and procedures that are part of the delivery of health care do not hinder the ability of people with disabilities to receive the same quality of care as other people. Where usual health care practices may impose barriers, modifications in policy or procedure may be necessary to assure access.

Reasonable accommodations depend on the particular needs of the patient and can include, but are not limited to:

- Providing interpreters or translators for people who are Deaf or hard of hearing;
- Providing large print versions of all written communications including forms filled in by patients;
- Ensuring that all written communications are available in formats that are compatible with optical recognition software;
- Reading all notices and other written forms/communications to patients upon request
- Assisting patients in filling out forms
- Ensuring effective communication to and from patients with disabilities through email, telephone, and other electronic means

H + H should conduct on an-site accessibility review of its facilities and an assessment of its capacity to provide accommodations such as ASL, alternative formats, and extended exam times. It should use a specific accessibility survey tool and have compliance plan and make access information available to the public. New York does not require a uniform survey instrument and allows self-assessment and attestations about accessibility. In California where on site surveys of primary care offices using an 86 item instrument the availability of height adjustable exam tables and accessible weight scales, while still low, and has improved over the years. In 2010 8.4% had height adjustable exam tables and 3.6% had accessible weight scales. By 2017 data showed that 19.1% of offices had adjustable exam tables and 10.9% had accessible weight scales.

Thank you for consideration of our comments and recommendations. For further information, please contact Heidi Siegfried, CIDNY's Health Policy Director, at 646.442.4147 or hsiegfried@cidny.org.

cphs*
*putting the public back in public health

City Council Hospital Committee: Oversight - Access to Specialty Care at NYC's Health + Hospitals.

February 25, 2019

Good afternoon,

My name is Anthony Feliciano; I am the Director of the Commission on the Public's Health System (CPHS). We believe in putting the public back in public health. For over 25 years, we have been addressing inequities in the care, treatment, delivery and distribution of health care services, programs, and resources. We like to thanks the City Council Hospital Committee for holding this hearing today on

Access to specialty care in the New York City safety net, already strained, is facing increasing pressure with cuts to health care at all levels of government. Access to specialty care out of reach for many, especially mental health. The specialist gap exists because few clinics for low-income patients have specialists on staff. The clinics often have no direct connection with the specialists, who are typically affiliated with hospitals or large practices. Even when they do have connections, they can't always arrange timely, affordable specialty care. Many specialists aren't eager to take low-income people because they aren't likely to be reimbursed well for the care of such patients, who are either uninsured, on Medicaid, or underinsured. While the Affordable Care Act opens up coverage to patients who didn't have it before, some carry deductibles that are so high they still can't afford to see specialists. The other factor is not having enough specialist representing ethnicities and people of color or speaking their language. This impacts the decisions to access the particularly specialty.

NYC has a unique hospital landscape: the city has the largest public (municipal) hospital system in the nation (Health + Hospitals), in addition to housing some of the most prominent academic medical centers (AMCs) in the nation. However, this has resulted in a two-tiered system, whereby low-income patients who are publicly insured (Medicaid), uninsured or underinsured disproportionately receive care in the public system, while privately insured patients are over-represented at private hospitals that play no or limited role as a safety-net provider. This inequitable and underrepresented situation can be also found in access to specialty care and elective care. Basically, patients are highly concentrated at a small number of hospitals by race and ethnicity: In addition, costs of specialty care vary from hospital to hospital network. However, specialty care cost many times far less at the H+H facilities, while

providing many times a higher standard of quality than certain private facilities.

Our public hospitals, community health centers and other true safety-net hospital facilities have always assumed the responsibility for a greater proportion of the care of the uninsured and low-income, immigrant and communities of color. But we all need to be concerned that the capacity of these safety-net providers, especially Health + Hospitals to care for them is always in jeopardy, especially for specialty care or diagnostic testing. In addition, why we can't look at H+H in a vacuum. Their ability to provide specialty care must be looked at from a comprehensive lens of inequity and a segregated health care system. Private hospitals can't survive without the public hospitals accepting patients of any socioeconomic level. This reality determines that something must be done to correct the inequality in how New York City's public and private medical facilities share the costs and revenues of medical care, especially specialty care.

In November 2018 NYC Health + Hospitals announced the expansion of its eConsult system, a tool that makes it easier for primary care providers and specialists to communicate about patients. And sometime in 2019, New York City will begin to guarantee comprehensive health care to all residents, regardless of someone's ability to pay or immigration status. NYC Care would provide a primary care doctor and will provide critical access to specialty care; prescription drugs; mental health services and hospitalization.

The City Council Hospital Committee and individual councilmembers where a public hospital is located should closely monitor and get updates on its implementation. We support these H+H efforts. We understand maintaining sufficient capacity (and staff) in the public hospital system to fulfill its mission as provider to both residents of adjacent communities as well as the marginalized populations served by H+H will continue being a challenge and we know that their still need fixes to various areas that impact access to specialty care and other forms of medical care.

We don't have all the data around H+H delivery of specialty care but we do have stories and issues that could impact access to quality specialty and clinical care. Major issues have been waiting times, referral delays, and the call center. The other concern is in H+H effort to insure everyone, which is an important goal, certain facilities we heard have been coercive in steering away people if they did not fit in pre-certified status for health insurance. It is important to know that fears still exist from immigrant to access health care due to federal threats to change what is determined as "Public Charge" and accounts of U.S Immigration and Custom Enforcement (ICE) at courts and

hospitals. Even if their pubic insurable, but have a family member that is not, the person may choose not to one Medicaid or private health insurance.

We have some recommendations:

Community Involvement

1. Ensure that community-based organizations are directly involved in maximizing these efforts, conduct outreach, and assessments with H+H. I am sure H+H as they done before will work with CBO's on this and to address concerns.

Patient Appointment -Scheduling Progress Clinics

- Establish a clear, uniform definition of measuring access in specialty care.
- Develop an electronic, automated, timely and accurate collection and tracking of of all outpatient specialty care clinics.
- Standardize the nomenclature and structure of scheduling appointments for specialty care clinics ensuring that patients scheduled matches capacity of clinic.
- Form a specialty care scheduling committee that serves as a governing body for guiding, developing and implementing new scheduling templates across all clinics. CBO's should be part of the committee.

All Clinic Team Communication Progress

- Improve daily clinic communication through defining staff roles and creating standard work for all staff from check-in to discharging of patients.
- Implement team based-care models in specialty clinics.
- Perform a gap analysis for providers, nurses and staff in each specialty clinic based on the population served in the network.
- Pilot QI training and leadership academy for specialty care management teams. Completed On-going All Endocrine, Orthopedics, OB/GYN, ENT clinics.
- Examine and address space mismatch in specialty clinics.
- Optimize eClinicalWorks training for specialty care providers
- Conduct needs assessment/gap analysis for resources needed to reduce stays and wait times at all pediatric and adult specialty care clinics

Staffing

- Ensure Safe Staffing and City Council should send a letter of support for the Safe Staffing legislation which NYSNA has spearheaded.

- Continue to engage front line staff in the improvement work through daily performance improvement huddles
- Institute countermeasures to improve specialty, procedural and surgical wait times
- Monitor weekly wait times for all specialty care clinics and develop targeted interventions for those clinics that have a wait time over clinical standards.

This current fiscal environment has significant and negative consequences in terms of delivering timely and high-quality specialty care, providing a positive patient experience, maintaining financial sustainability, and satisfying regulatory standards. We want to ensure that H+H succeeds in their efforts to improve access and quality of specialty care.

Thank you,

Anthony Feliciano

Director of the Commission on the Public's Health System

110 Wall Street Suite 4006

NY NY 10005

646-325-5317

afeliciano@cphsnyc.org

American Federation of State, County & Municipal Employees, AFL-CIO
125 BARCLAY STREET • NEW YORK, NY 10007-2179

Executive Office
Telephone: 212-815-1500
Fax: 212-815-1516

District Council 37 AFSCME AFL-CIO

Testimony
New York City Council Hospitals Committee Hearing
February 25, 2019
By Oliver Gray
Associate Director, District Council 37, AFSCME, AFL-CIO

Good afternoon and thank you for the opportunity to testify before you, the Hospitals Committee of the New York City Council. I am Oliver Gray, Associate Director of District Council 37, AFSCME. Our union represents over 18,000 members at the NYC Health and Hospitals system and serves over 1 million patients.

Distribution of Indigent Care Pool funds - an opportunity exists in this year's state budget to correct a wrong that has persisted for many years and negatively affected safety net hospitals, including NYC Health and Hospitals because the funds are not distributed according to the proportion of care provided to the uninsured. A working group convened by the state with representative stakeholders evaluated several options. Our union endorses the proposal known as the H & H & Community ICP proposal which would draw down additional federal matching funds through an enhanced Medicaid rate, end the distribution of funds to hospitals with high profit margins that are not actually providing care to the uninsured and protect the state from larger federal cuts. We are asking the city council members for a resolution in support of this proposal, which will be introduced as legislation shortly.

Single Payer Systems - There is much discussion in the state and the country about a single payer system or a Medicare for All system. The number one issue for Americans in the 2018 midterm elections was health care. Does any other issue touch so many families so closely? Fortunately New York City is already a leader because of the commitment to serve all patients regardless of status or income. In order to do so effectively, we must invest in that system. It is unclear what the outcome of other legislative efforts will be towards building a different system. Rather than spending time and energy reinventing the wheel we should make sure that the system we have is the best available for all New Yorkers.

Primary Care and Specialty Care Access - Our union is strongly in support of the proposal to invest $100 million in the H & H in order to

provide critical primary care and specialty care to New Yorkers, regardless of their insurance or immigration status. We want our neighbors, our co-workers, our fellow passengers on the subway and bus to be healthy. Some of us are fortunate to have private health insurance through our jobs, including the excellent plans available to city workers. However, more than 600,000 New Yorkers and their families are still uninsured. It's possible they are not able to access insurance despite many programs that exist. We cannot leave these people out of the health care system. If we do, it creates a weak link in the chain of a strong New York City.

With the additional funding, more primary care doctors and health care providers will be added to the system. More ambulatory care clinics can be opened in convenient locations with extended hours to meet the needs of the patients. Three Express Care Clinics (Elmhurst, Lincoln and Jacobi in March) with extended hours were recently opened or about to open that can absorb patients with urgent care needs that do not need to be handled in the Emergency Room. With all of this expansion comes additional need for clerical and clinical support staff. These are good jobs with benefits that provides additional stable employment in the community.

Specialty Care - the stated purpose of the hearing is to discuss Access to specialty Care so I am including some highlights of the specialty care available and how our members support that care.

There are a number of areas where H & H is providing the bulk of care to New Yorkers covered by Medicaid or uninsured and that includes HIV services and mental health services. Our members are integrally involved in the support areas of these medical services. Staffing is always an issue in order to make sure patients can get faster access to appointments and appropriate care, so we look forward to additional investments in these areas.

H & H provides specialty care areas in a number of disciplines including but not limited to Cardiology, Diabetes, Bariatric and Trauma. In each of these areas, more investments in additional preventative care through increased access to ambulatory care clinics will lessen the need in the future for interventional care for seriously ill patients. Our Social Workers provide counseling on long term and crisis intervention, thereby preventing more serious mental health issues. Our Addiction Counselors and Peer Counselors provide group support for harm reduction and ways to get into maintenance treatment for substance abuse.

Health and Hospitals has been through the fire in these last couple of years. Under the leadership of Dr. Katz, who told me he would not cut his way out, he would grow his way out, and with the support and cooperation of our hard working members, they are well on the road to a strong system that will provide the best health care to all New Yorkers who come through their doors.

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

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

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Anthony Fellano

Address: CPHP

I represent: _____

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

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

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Anne Bove

Address: 48-53 45th St A'

I represent: CPHS / NYSNA

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

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

☐ in favor ☐ in opposition

Date: 2/25/19

(PLEASE PRINT)

Name: Oliver Gray, Associate Director

Address: 125 Barclay Street

I represent: DC 37

Address: _____

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

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

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

☐ in favor ☐ in opposition

Date: 2.25.2019

(PLEASE PRINT)

Name: Dave Chokshi, MD

Address: _____

I represent: New York City Health + Hospitals

Address: _____

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

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

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

☐ in favor ☐ in opposition

Date: 2.25.2019

(PLEASE PRINT)

Name: Mitchell Katz, MD

Address: _____

I represent: New York City Health + Hospitals

Address: _____

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

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

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

☐ in favor ☐ in opposition

Date: 2.25.2019

(PLEASE PRINT)

Name: Matt Siegler

Address: _____

I represent: New York City Health + Hospitals

Address: _____

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

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

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

☐ in favor ☐ in opposition

Date: 02.25.19

(PLEASE PRINT)

Name: HEIDI SIEGFRIED

Address: 841 BROADWAY, 301

I represent: CENTER FOR INDEPENDENCE

Address: OF THE DISABLED

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