CITY COUNCIL
CITY OF NEW YORK

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TRANSCRIPT OF THE MINUTES

Of the

COMMITTEE ON HOSPITALS

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HELD AT: Committee Room – City Hall

B E F O R E: CARLINA RIVERA
Chairperson

COUNCIL MEMBERS:
DIANA AYALA
MATHIEU EUGENE
NARK LEVINE
ALAN N. MAISEL
FRANCISCO P. MOYA
ANTONIO REYNOSO

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

Mitchell Katz
President and Chief Executive Officer at New York City Health and Hospitals

Dave Chokshi
Chief Population Health Officer at New York City Health and Hospitals

Matt Siegler
Senior Vice President for Managed Care at New York City Health and Hospitals

Anne Bove
Board of Directors for NYSNA and CPHS

Oliver Gray
Associate Director of District Council 37, AFSCME

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

Anthony Feliciano
Director of the Commission on the Public's Health System, CPHS

[gavel]

CHAIRPERSON RIVERA: Good afternoon everyone, I am Council Member Carlina Rivera, Chair of the Committee on Hospitals and I'd like to start off by acknowledging my colleagues and fellow members of the committee, thank you Diana Ayala for being here. So, today we'll hear from representatives of Health and Hospitals and members of the public about access to specialty care services at Health and Hospitals. H and H provides a range of comprehensive specialty care services including but not limited to care for those with asthma, cancer, geriatric needs, sickle cell, mental health needs, and HIV and AIDS and the list goes on. Although H and H offers comprehensive specialty care services, accessing these services in a timely fashion is sometimes challenging. According to Dr. Katz for example in testimony before this committee in February 2018 a person could wait up to six months to receive an appointment for specialty care services at Health and Hospitals. I know that Dr. Katz and H and H have been working hard to lower wait times and improve access to these services and I'm looking forward to hearing about the progress that has been made and the

1
2 challenges that still exist to ensure that patients
3 have access to the specialty care they need within a
4 reasonable amount of time. Now the availability of
5 appointments is not the only way to measure access to
6 care, as was highlighted in a hearing this committee
7 held in November of last year on access to
8 transgender and gender non-conforming friendly health
9 services, many TGNC and B individuals do not seek
10 needed healthcare services due to fear of being
11 mistreated by their health care provider. Individuals
12 with disabilities despite federal, state and local
13 laws requiring equal access to health care services
14 still faced physical accessibility challenges in
15 accessing care according to the centers for Medicare
16 and Medicaid services and finally studies have shown
17 that individuals with limited English proficiency may
18 face increased barriers to accessing health care.
19 Today I want to hear from members of the public
20 regarding any challenges they face in accessing
21 specialty care services at H and H. It is critical to
22 ensure that specialty care is accessible to all New
23 Yorkers and I'm looking forward to hearing about the
24 policies and strategies H and H has in place to
25 achieve this goal. And to start I'd like to invite

Health and Hospitals; Mitchell Katz; Dave Chokshi, okay; Matt Siegler, okay. I hope I pronounced everyone's name correctly, feel free to let me know. What… we want to administer the oath. We trust you but we have to do it.

COMMITCHELL KATZTEE CLERK: Can you state your name for the record please and do you affirm to tell the truth, the whole truth and nothing but the truth in your testimony before this committee and to respond honestly to Council Member questions. Thank you.

MITCHELL KATZ: Sorry, I have to start over, is it… as you know I'm a primary care doctor and I'm a strong believer in the value of primary care for keeping patients healthy. We've made great progress on access to primary care and patients can now see a primary care provider in our system within one to two weeks allowing that some patients may, may wait longer if they wish to see a particular doctor in a particular clinic. But much as I believe in primary care, sometimes my patients need specialty care, they may have severe congestive heart failure, need to see a cardiologist or a broken bone and need to see an orthopedist. In serious cases, Health and

2 Hospitals can ensure immediate access to specialty
3 care, I could call right from my clinic, I can reach
4 a consultant, I can send someone to the emergency
5 room, I can send someone to a clinic. If I have a
6 patient for example who comes with an acute loss of
7 vision, I'm going to get them seen that day because
8 that's what they need. But when its less than an
9 emergency, I think that's where what you had said
10 Chair Woman Rivera can be an issue, as… where people
11 might wait longer for something that's very important
12 but isn't an emergency such as a persistent
13 Gastrointestinal reflux which is causing them bad
14 heart burn or severely arthritic joint that perhaps
15 needs replacement. Part of the challenge is that
16 reimbursement for uninsured persons needing
17 outpatient specialty care is very limited and
18 therefor a person without insurance in New York has
19 few options for where they can receive specialty care
20 at an affordable price. This is different if you
21 think about it from emergency care or inpatient care
22 where all of the hospitals in the city participate
23 both because of the EMTLA responsibility that they
24 cannot deny care due to inability to pay as well as
25 the state Chair's disproportionate share hospital

2 dollars for people to be in the hospital. Also, in
3 the area of primary care, New York City has some
4 wonderful federally qualified health centers that are
5 able to provide great primary care and they get an
6 enhanced rate on Medicaid as well as federal dollars.
7 But in this particular niche of outpatient specialty
8 care there is really no state or federal
9 reimbursement for the care of the uninsured. So,
10 that's why and people rely very heavily on Health and
11 Hospitals and also why it can be challenging for us
12 to have enough services. I'm incredibly proud of the
13 fact that we offer outstanding specialty care
14 regardless of whether or not people have insurance,
15 that's the greatness of Health and Hospitals but it
16 also means that if we're the only one who's really
17 providing that service having sufficient access can
18 be difficult. Like many things in a large system such
19 as ours there's a lot of variation in the wait times
20 which I think leads to a certain amount of confusion
21 about well how long do you have to wait. Someone can
22 go to a particular clinic and be told well its three
23 months and our system isn't always sophisticated
24 enough to know well actually if they went to that
25 other hospital at H and H it would only be two weeks,

we're not yet at that level of competency but we're going to get there as I'll explain soon. So, the, the most important initiative and why I wanted to have Dr. Chokshi here with me is electronic consultation. So, electronic consultation allows a primary care doctor like me to put in a consult to rheumatology, to cardiology, to orthopedics and get back an answer for my patient. Often that answer is something that I can do myself as a primary care doctor. So, in the case of congestive heart failure it might be that the patient needs a new medicine that would make their breathing easier, the cardiologist can tell me that the person doesn't need to wait for a visit they can simply tell me what it is that I should be doing. The… if the patient does need to be seen then now, we have a, a system to be able to make that happen. To date eConsult is live in over 100 clinics across ten facilities including adult medical and surgical subspecialties, behavioral health and pediatrics subspecialties. Nearly 8,000 referrals per month are managed which is up from just 2,300 in January of 2018 and I think this is one of the reasons Chair Rivera that we have made progress and I'm happy to say that we no longer have six month waits but some,

2 some of our outliers are still as much as three
3 months so there’s still… there’s still progress to be
4 made. For a set of 14 specialty clinics using
5 eConsult, for over a year, we saw a 23 percent
6 reduction in overall wait times. Second, to make the
7 system better we need to improve our scheduling
8 systems and our referral practices making sure that
9 each appointment is the right length of time and that
10 we can send people from the emergency department to a
11 real appointment rather than telling them at the
12 emergency department okay, well orthopedic clinics
13 starts at nine o’clock on Tuesday. Well if they just
14 go to orthopedic clinic without an appointment nine
15 o’clock on Tuesday, they’re going to wind up waiting
16 because there’s already somebody with a nine o’clock
17 appointment on Tuesday. Third, we need to invest in
18 new clinical services and providers to help us meet
19 the demand for specialty care. We have recently
20 approved business plans to grow HIV care,
21 gastrointestinal care, cardiac care. I want to
22 address our waiting times by making smart investments
23 wherever we can. I also want to acknowledge publicly
24 that while we’re doing a lot to improve specialty
25 care there are some amazing things at Health and

2 Hospitals and one of the ones that, that I think is
3 so amazing is that Metropolitan Hospital provides
4 gender affirming surgeries to transgender and non-
5 conforming patients and it… to my knowledge there's
6 no other public hospital in all of the U.S. who does
7 that and that includes San Francisco where I
8 originally was Director. So, I mean that's, that's an
9 amazing thing. Our behavioral health services, very
10 advanced, very specialized. New York City in part
11 because of the tragedy of the AIDS epidemic was a
12 leader in many HIV areas, I think that we do well in
13 the care of the disabled although I think there's a
14 lot more that we can do around our equipment and with
15 that I, I look forward to any questions and telling
16 you more about our system. Thank you.
17 CHAIRPERSON RIVERA: Thank you. So, you
18 mentioned a, a few things I, I just wanted to get a
19 little bit more detail on. You said that the person…
20 the average person doesn't have to wait six months
21 anymore for an appointment but on average how long
22 does it take for a patient to see a specialist?
23 MITCHELL KATZ: Okay, so in, in fact I
24 have… I brought my table because I knew you would be
25 smart enough to ask that question. So, there is both

2 the average and the range and I'll, I'll go through
3 and tell you what it is in each specialty, it's not
4 that long a list and at some point, you could say
5 I've… I got the idea Mitch if you… if you so wish.
6 So, cardiology, the shortest wait time in our system
7 two days, longest wait time in our system 38 days but
8 North Central Bronx is an outlier with three months.
9 Endocrine, shortest wait time is at Lincoln, longest
10 wait time Jacobi three months. Gastrointestinal
11 shortest wait time Harlem one day, Jacobi ten weeks
12 and I'd say Jacobi is an outlier and having to
13 prepare this data for you was really helpful because
14 it, it tells me I need to do more about specialty
15 access at Jacobi because it turned into the longest
16 wait time. Renal, Lincoln 17 days, Jacobi three
17 months. Neurology, Lincoln one day, Bellevue 34 days,
18 Jacobi was an outlier at three months. Ophthalmology
19 five days was the shortest, Jacobi was… again the
20 longest, three months. Podiatry, Belvis one day,
21 Harlem three months and this is a good time to stop
22 and say… [cross-talk]
23 CHAIRPERSON RIVERA: That's a pretty…
24 that's pretty… okay, did you want to stop… [cross-
25 talk]

2 MITCHELL KATZ: Okay… [cross-talk]
3 CHAIRPERSON RIVERA: …and say something?
4 MITCHELL KATZ: And, and I won't read the
5 rest but, but it's a good place to end and say
6 interesting it also shows you the heterogeneity
7 because Bell… Harlem which is the fastest for
8 cardiology and GI is the longest for podiatry and I
9 think that tells you just another thing about our
10 system which is that it's heterogeneous… it's
11 heterogeneous. It isn't the same in every place and
12 when we have the ability through epic to really
13 instead of saying to a person who comes to, to Jacobi
14 I'm sorry it's three months saying if you go to
15 Harlem and specialty unlike primary care sometimes
16 it's one visit, we could get you in tomorrow and
17 that's part of how I see us improving the system.
18 CHAIRPERSON RIVERA: Alright I think
19 that's interesting because I, I wondered how related
20 some of the specialty care services are to
21 demographics, you know when you… when you look at
22 specifically communities of color and some of the
23 issues that they're facing I know that in black and
24 brown communities diabetes is a very, very serious
25 issue and so I always think of people who are

2 suffering from diabetes and podiatry and all these
3 things are very related because of some of the
4 symptoms and the… and that they could suffer so I
5 guess in, in… I'd love to maybe chat with you another
6 time about the demographics relating to the hospital
7 and the services that you offer at each facility but
8 before… but, but before that I want to ask… so, it
9 sounds like you have a number of specialty care
10 services that you provide, are there any services
11 that H and H currently does not provide?
12 MITCHELL KATZ: We do not do bone marrow
13 transplants, we do not do renal transplants, we do
14 not do liver or cardiac or pancreatic transplant, we
15 do not treat some… what… of the leukemias… [cross-
16 talk]
17 CHAIRPERSON RIVERA: Do you refer them to
18 another… [cross-talk]
19 MITCHELL KATZ: …so, we refer… [cross-
20 talk]
21 CHAIRPERSON RIVERA: …hospital?
22 MITCHELL KATZ: Absolutely but we do not
23 do those on our own. Dr. Chokshi is there anything
24 else we don't do?
25

2 DAVE CHOKSHI: No, I wouldn't add
3 anything to the list, I would just emphasize, you
4 know particularly with our academic partnerships it
5 allows us to, to make referrals to other coordinated
6 academic medical centers where those services can be
7 provided.
8 CHAIRPERSON RIVERA: And so, I know you
9 also mentioned in your testimony about outpatient
10 revenue stream and of course reimbursement is always
11 an issue, is the services that you provide directly
12 related to the type of insurance that you take?
13 MITCHELL KATZ: Well we, we are… I'm very
14 proud we're agnostic at the level of the provider,
15 right, so we'll… the providers have no idea what
16 people have… [cross-talk]
17 CHAIRPERSON RIVERA: But you, you take…
18 [cross-talk]
19 MITCHELL KATZ: …and… [cross-talk]
20 CHAIRPERSON RIVERA: …all insurance or…
21 MITCHELL KATZ: We don't take all
22 insurances because some of the insurances won't pay
23 us a fair rate so Matt Siegler who's here does our
24 negation and, and we've brought to you this issue
25 and, you know I don't see any reason I can't speak

2 openly, I, I joined Emblem as a city employee because
3 I wanted an insurance that would let me be seen at
4 Health and Hospitals where I wanted to be primary but
5 that would cover my children who are still in
6 California till June. So, I couldn't join Metro Plus.
7 For a new primary care appointment, I see this on my
8 statement, they paid us 41 dollars and I can tell
9 from my statements that when I was in California and
10 had the bicycle accident they were paying the
11 California hospitals significantly higher rates,
12 right and so, you know yes, theoretically we would
13 want to take all insurance but if they're… I mean I
14 don't think that anybody can break even for a primary
15 care appointment at 41 dollars, that's a new
16 appointment, that's an old contract and Matt is
17 working on re-negotiating it but the insurance can't
18 be taking advantage, that's not fair, city subsidy is
19 meant for the uninsured, it's not meant to subsidize
20 insurance companies. So, there's some insurance
21 companies that just won't pay us fair rates at all.
22 CHAIRPERSON RIVERA: Do your H and H
23 facilities accept the same insurance like every
24 single facility accepts, accepts the same insurance?
25

2 MATT SIEGLER: Predominately do, some of
3 our skilled nursing facilities there are unique
4 contracts that do or do not cover post-acute care but
5 yes, across the system we contract as one entity.
6 CHAIRPERSON RIVERA: Are there… are there
7 any patients that you have to turn away because of
8 the, the insurance that they have?
9 MATT SIEGLER: No, we treat everybody
10 regardless of their ability to pay, you know if
11 people are coming in for elective care and we don't
12 take their insurance we will advise them to go to a
13 participating provider because the bill is
14 potentially higher if you're seeing an out of network
15 provider but we never turn anybody away.
16 CHAIRPERSON RIVERA: So, there is a
17 chance that a parson receiving primary care at H and
18 H cannot receive specialty care because a specialist
19 won't accept their health insurance?
20 MATT SIEGLER: Anyone that we… all of our
21 insurance contracts cover both primary and specialty
22 care so I… [cross-talk]
23 MITCHELL KATZ: But I think… I think to,
24 to the… and you know this is the horrible world of
25 perverse incentives, I think there are people who

wouldn't be smart financially for them to get their care with us because we would be out of network for them and so, so a… if we were more money grubbing we might say yes join us but we… I mean if we see somebody and we know that if they go to us, they're going to get a big out of network bill we'll tell them we don't… we… and it is a true… I mean a… some is the vocabulary, if, if you're out of network it's kind of a true statement that we don't take your insurance, we're out of network, generally it's better to say we're out of network, it… but I think sometimes as a shorthand people say we don't take your insurance.

CHAIRPERSON RIVERA: So, you gave me a, a very good table of some of the specialty care services at every facility and on average what the wait times are and I know that some of them are as long as 90 days, I don't think I heard anything longer than that…

MITCHELL KATZ: At the current time nothing is longer than 90 days.

CHAIRPERSON RIVERA: Do… so… and I, I clearly wait times vary based on specialty, is there

2 a difference in how long a, a former patient versus…
3 or a current patient versus a new patient waits?
4 MITCHELL KATZ: No, I don’t think so.
5 DAVE CHOKSHI: In brief no, there’s not a
6 significant difference between a new patient
7 appointment or a revisit appointment, there, you know
8 are always certain clinical circumstances that will
9 create, you know exigencies where a new patient may
10 need to be seen more quickly and you know we both
11 have mechanisms in place to try to account for that
12 and are building further mechanisms in large part,
13 you know through eConsult so that when someone does
14 need to be seen urgently there’s a way to expedite an
15 appointment and just because of the nature of some
16 clinical problems that is more often the case for a
17 new appointment than a revisit appointment.
18 CHAIRPERSON RIVERA: And, and I’ll ask
19 you about eConsult in a second but if a patient
20 doesn’t have insurance and there is a specialty care
21 service that you don’t provide what happens when you
22 refer them?
23 MATT SIEGLER: They would get emergency
24 Medicaid, but it can be an issue, I mean it… again
25

2 I'll… let me defer it back to Dr. Chokshi you've been
3 in the system longer, it's, it can be an issue.
4 DAVE CHOKSHI: In, in certain cases yes,
5 it can be an issue, you know we'll strive in a case
6 by case basis, you know to make sure that people who
7 need care we figure out a way to deliver the care and
8 then we figure out a way to, you know have the
9 finances work around what a given patient needs.
10 MITCHELL KATZ: It has to be
11 individualized based on the person and why it… I mean
12 in general, I mean if you ask sort of the, the, the
13 state what they'd say is that they should qualify for
14 state emergency Medicaid in that circumstance. If
15 they so urgently need a service and the only services
16 that we don't provide are the, the kinds of things
17 that constitute emergencies like you need a new
18 kidney but as Dr. Chokshi is also saying it isn't so
19 easy to arrange and it requires a physician to get on
20 the telephone and the nonprofit hospitals do have an
21 obligation as non-profits to provide charity care and
22 so we looked to, you know sometimes based on
23 neighborhoods, sometimes at the hospital… what
24 affiliations the hospital has; Harlem has an
25 affiliation with Columbia which is different than

2 Bellevue has a… an affiliation with NYU we'll, we'll
3 try to work the affiliations… the Sloan Kettering
4 will take a patient with cancer that's serious and we
5 try to… but it's at that level that you have to do
6 it.
7 CHAIRPERSON RIVERA: No, the, the
8 patient… the whole navigating the system I know can
9 be incredibly intimidating and for someone who is
10 undocumented, I mentioned limited English
11 proficiency, you know I, I, I could imagine that it's
12 very stressful so besides those people that are
13 helping someone navigate a system and I know you have
14 a number of navigators, social workers, you know
15 people specifically helping some of your geriatric
16 patients, are you hiring new specialists to meet the
17 demands?
18 MITCHELL KATZ: We are, we are and, and
19 you… this hearing and just in general our looking at
20 this is helpful, right, because it… you… we want to
21 hire what we need where we need it and it isn't
22 always the same for hospitals so, so trying to…
23 obviously what you want is you want supply to equal
24 demand, it's not that each hospital needs three
25 urologists, one may need two and one may need five

2 based on volume and, and as you were talking about
3 patient demographics so now that we've with our
4 eConsult and eliminating the really long six month
5 ones we're going to work on what are the additional
6 specialties we are… again it's, it's quite… like I
7 was involved with getting a one gastroenterologist to
8 Elmhurst because that was an area where they had
9 unrealistically long wait times because patients only
10 are seen by specialists once or twice unlike primary
11 care, one person can make a huge difference in your
12 wait times and sometimes the wait times happen
13 because we have two and somebody retires so it's,
14 it's, it's like micro climax that's why we have to do
15 a better job of at least… I mean we're not going to
16 send the NCB patient to Coney Island but you know in
17 areas like Jacobi, Harlem, Mets, Lincoln, right in
18 those kinds of areas we need… because we'll do the
19 transportation, it's a lot easier for me to transport
20 somebody than it is to come up with a specialist,
21 right, if I already have a urologist and again
22 urology is a good example, you don't generally need
23 to see them over and over again, it's one visit, send
24 them… then I'd rather pay for the transportation and
25 get them to their appointment.

CHAIRPERSON RIVERA: So, I, I want to recognize Council Members Moya and Eugene and you have a question, okay. So, I'm actually going to Council Member Eugene if you're ready to ask your question I'm willing to turn the floor over to you if you're ready to ask your question.

[off mic dialogue]

CHAIRPERSON RIVERA: If you'd like, okay.

COUNCIL MEMBER EUGENE: Thank you Madame Chair. As a matter of fact, I got two very important public hearings at the same time, Hospital and Health and they are connected. So, my question is we know there's a… have disparity in the community in New York City depending on, on where you live, which… you go to this is a reality and we know also that there's a different type of resources or ability to hire the best doctors depending, you know and… which hospital we are talking to because I know that the hospital they are trying… they are trying to hire the best specialist, the best specialists because they have the resources to do that and they got the best specialists and also they have the… enough resources there would be quote, unquote able to provide a higher quality of health care, higher, better than

the public, you know hospital, my question is what do you have in place, what we have in place to ensure that Department of Hospital, you know can hire also good specialists, doctors with the same quality of expertise in order for you to provide the best quality of health care to the patient?

MITCHELL KATZ: Well thank you Council Member for raising that and, and you know it's absolutely my commitment that, that people should be seen by the best doctors possible regardless of their income, regardless of their backgrounds, regardless of geographically where they live and, and as you know better than anyone even within similar economic pockets the… there are differences by ethnicity in terms of what people need, the, the afro Caribbean community around Kings County is different than the West African community that's around Harlem and we need to address both and we need to do both well, getting the data really helps me in understanding what our needs are and we're going to do our very best to, to hire the highest quality clinicians. Also, you… the academic affiliations in the case of Kings with SUNY is helpful in getting the best

2 doctors because many of the best doctors want to
3 maintain an academic affiliation and a teaching role.
4 COUNCIL MEMBER EUGENE: Thank you very
5 much, you're talking about Kings County which is in
6 my district, a wonderful institution, you know
7 providing good quality health care to people from New
8 York and as a matter of fact, fact they are a trauma
9 center also which is very, very important but I think
10 that, you know they have their challenges also in
11 terms of resources so we know that hospitals they are
12 competing, competing for best quality of doctors,
13 best technology and we know that the resources is
14 really fundamental for hospitals to hire best
15 physicians, best expert, what can we do, we in the
16 City Council to work together with the public
17 hospital to ensure that you have what it takes to put
18 you in the position to compete and to hire the best
19 physicians into our care, the best technology
20 possible to provide the best quality of health care
21 to all cost insurance?
22 MITCHELL KATZ: I'm, I'm happy to, to
23 work with all of you and I would say, you know we
24 promoted Dr. Donnie Bell who was… who continues to
25 see patients as a neuroradiologist at Kings,

2 phenomenal physician, graduate of Howard and did
3 his residency at Harvard and you know my
4 commitment to you is to continue to work towards
5 getting the very best physicians throughout our
6 system.
7 COUNCIL MEMBER EUGENE: Thank you, thank
8 you Madame Chair, you have been very gracious, thank
9 you very much, I appreciate it, thank you.
10 CHAIRPERSON RIVERA: Council Member
11 Ayala.
12 COUNCIL MEMBER AYALA: Thank you Council
13 Member. So, my questions are obviously around the
14 accessibility for individuals with disabilities, it's
15 something that, you know we've discussed in my
16 committee several times and that I'm pretty curious
17 about because I know that some of the… well many of
18 the HHC or H and H facilities are pretty outdated and
19 I wonder where we are in terms of retrofitting these
20 facilities if any of them have in fact been
21 retrofitted to date to accommodate or to better
22 accommodate individuals with disabilities?
23 MITCHELL KATZ: Well thank you so much
24 for your work in this area, I mean H and H, other
25 institutions need to go so much further on disability

2 access and just to mention what I… sort of what I'd
3 say a humorous story when I was just back after being
4 hit by a, a car I went to take care of my patients,
5 I'm at Gouverneur I need to use the restroom happily
6 Gouverneur has a really nice disability restroom, go
7 in with my wheelchair, door is wide, toilet has the
8 bar, sink is, is low, I go to get a towel I can't
9 reach it because nobody has thought of the person in
10 the wheelchair trying to get a towel, right and so
11 I'm there with like my wet hands trying to, you know
12 manipulate the thing and using my shirt to dry
13 somewhat and I thought it was a fascinating example
14 even though it's incredibly trivial because it costs
15 nothing to lower the towel rack, right… [cross-talk]
16 COUNCIL MEMBER AYALA: Yeah… [cross-talk]
17 MITCHELL KATZ: No money at all, all it
18 requires is that you think of the world from the
19 point of view of somebody who has a disability and
20 clearly in our placement of that towel rack we
21 weren't thinking of it. The Council has helped us,
22 while it's true that the facilities, our facilities
23 are older most of the need is around types of
24 appropriate tables. So, for example if a woman needs
25 a pap smear and she is a quadriplegic making sure

2 that the table is appropriate, it's the bathrooms,
3 generally it's not the doors, generally it's not the
4 doors and the ramps that was early ADA but it's
5 really the bathrooms, the examining table, we have
6 received funds for it and each of the projects are on
7 schedule but I would say that we have a ways to go.
8 Sydenham is 95 percent complete, Morrisania is 85
9 percent complete, Cumberland is in design phase,
10 Woodhull radiology for mammograms was completed in
11 2018, so I just say I'm very committed to this issue,
12 I appreciate your advocacy, there's a lot more that
13 could be done.
14 COUNCIL MEMBER AYALA: I… you know I
15 just… I, I, I find it really frustrating and this is
16 not an H and H thing but it's just basic, you know
17 human rights needs, I, I, I for example have my, my,
18 my father who's disabled, he's, he's obese and I, you
19 know remember taking him to the hospital, I won't
20 mention the hospital, it was a private hospital and
21 him being very uncomfortable, he had a strangulated
22 hernia at the time and was in a lot of pain for well
23 over 12 hours because they couldn't figure out if it
24 in… what in fact… you know if, if in fact it was a
25 strangulated hernia because he needed to have an MRI,

2 the fact that he was, you know obese didn’t allow him
3 to use the MRI that was available in the hospital,
4 right, so they require the use of an open MRI which
5 then merited him having to be moved to a different
6 hospital which was further away from home where they
7 did provide that service and he was able to have
8 surgery that night and where it was pretty evident
9 from the moment that he got there that they… these…
10 that this hospital specialized on individuals with
11 obesity related, you know medical care needs and so
12 I… had I not like you experienced it firsthand I
13 would never have known but it was very frustrating to
14 watch someone that you love not only have to go
15 through that level of extreme pain because the
16 medical equipment was not available but the
17 imposition that placing or having to remove a patient
18 from their local hospital to an outer, you know
19 district hospital where now family… visiting,
20 visiting becomes a problem, I don’t know the… when
21 was the last time you were hospitalized but the last
22 time I was in the hospital I, I was going insane, you
23 know I… my, my mental health was declining, it’s a…
24 it’s very, you know debilitating just to be there and
25 so the, the support network, right, is important and

2 so by removing people from their communities and
3 putting them in hospitals because we don’t have
4 access to the appropriate medical equipment is mind
5 boggling so I wonder is that something that H and H
6 hospitals is also looking into, the, the open MRIs
7 for not only the… not only people with obesity but,
8 you know an individual that may be unable to use a
9 regular MRI machine?
10 MITCHELL KATZ: That’s a good point, I, I
11 have a patient who because of developmental
12 disability needed an MRI and couldn’t withstand the
13 closed one and I did have to send her out, I mean in
14 her case it was to an out… it was an outpatient
15 procedure so it wasn’t the tragedy for your father
16 but no, at the current time we do not have anywhere
17 in H and H an open MRI, MRIs are very expensive as
18 you know. I think that the… but the big point that I
19 take from your testimony is, the problem is in the
20 system not the person with the disability.
21 COUNCIL MEMBER AYALA: That’s right.
22 MITCHELL KATZ: It’s not their problem,
23 it’s our problem, we are failing to meet their needs
24 and everything from the towel rack to the open MRI
25 should be provided and it’s just… [cross-talk]

2 COUNCIL MEMBER AYALA: That's right…
3 [cross-talk]
4 MITCHELL KATZ: …a question of, you know
5 and what's speed can we get there.
6 COUNCIL MEMBER AYALA: So, the… so, so
7 that brings me to my, my next question, is there
8 within the H and… H and H portfolio a, a person who
9 is tasked with helping design for individuals with
10 disabilities in the hospitals like a… you know a
11 coordinator of sorts, other agencies have them I
12 wonder if H and H has somebody on staff?
13 MITCHELL KATZ: We do, we do and, and I,
14 I, I think that's totally important. Again, just to
15 divert of how common it is, I built an outpatient
16 center in Los Angeles and one of the things that
17 turned out to be wrong with it is that the ramp was
18 too steep so the ramp which was 100 percent compliant
19 with ADA which is what the builder said when I
20 complained, they said well it's 100 percent compliant
21 but it turns out that a ramp complying with ADA is
22 based on the idea if someone is going to push you not
23 that you're going to self-propel but of course we're
24 supposed to… we should be encouraging people to be as
25 independent as possible so we had to retrofit the

2 ramp to allow… my point being that you're right, that
3 you need… it's an expert just because you get… the
4 ramp fits the ADA doesn't make it acceptable, it may
5 make it legally acceptable… [cross-talk]
6 COUNCIL MEMBER AYALA: Exactly… [cross-
7 talk]
8 MITCHELL KATZ: …but it doesn't mean that
9 it fulfills the spirit of the ADA which is to allow
10 people independence, so we'll keep working on it and
11 appreciate your involvement.
12 COUNCIL MEMBER AYALA: I mean anything
13 that I can do to kind of help expedite it because I…
14 while I appreciate, you know the understanding on why
15 we need to be where we need to be to, to be more
16 accessible to the individuals with disabilities I
17 expect a level of expediency that I don't really
18 necessarily see in government and I'm not… again this
19 is not a, a… [cross-talk]
20 MITCHELL KATZ: I appreciate that…
21 [cross-talk]
22 COUNCIL MEMBER AYALA: …a Dr. Katz issue
23 but I think that when we talk about individuals with
24 disabilities and the elderly for some reason there is
25 then this lack of, you know urgency in getting things

2 done. Do you… do you by any chance happen to know how
3 many… how many people with disabilities are referred
4 out of the H and H portfolio because of an inability
5 to provide services or an inaccessibility…
6 MITCHELL KATZ: I don't, I, I mean the
7 big one that comes all the time is the open MRI, I
8 mean that's how I learned because as a provider I
9 said I have a patient who needs an open MRI what do I
10 do and someone brought me the form and said you, you
11 send them to this place…
12 COUNCIL MEMBER AYALA: Which makes no
13 sense because they're in the middle of an obesity
14 epidemic, right and… [cross-talk]
15 MITCHELL KATZ: Right… [cross-talk]
16 COUNCIL MEMBER AYALA: …we don't have a
17 way to treat individuals with obesity and public and
18 private hospitals for the most part.
19 MITCHELL KATZ: I'd be happy to go…
20 [cross-talk]
21 COUNCIL MEMBER AYALA: In, in fact…
22 [cross-talk]
23 MITCHELL KATZ: …back, I don't know what
24 the cost of an open MRI is but I, I mean you can… we
25 have space because they put them in trailers these

2 days so it's entirely… you don't have to be… it's not
3 like the old days where you had to like to build the,
4 the special room so now they can do them in trailers
5 and we have land but I can't answer the question of
6 what… I'll, I'll ask… I'll ask Matt to, to put that
7 on our list of business plans is what would it cost
8 to, to have one.
9 COUNCIL MEMBER AYALA: Yeah, that would
10 be really important. And just, just a point of
11 clarity, you mentioned the exam tables for women who
12 are coming in for gynecological exams are those
13 already up to code?
14 MITCHELL KATZ: So, we have… they are in
15 some but not every place yet.
16 COUNCIL MEMBER AYALA: So, how does a
17 woman coming in for a gynecological exam now, today
18 at a hospital that's not… [cross-talk]
19 MITCHELL KATZ: It would… [cross-talk]
20 COUNCIL MEMBER AYALA: …equipped get the
21 treat… [cross-talk]
22 MITCHELL KATZ: We would recommend that
23 a… and it is true that as a primary care doctor don't
24 usually do a GYN exam on the same visit as my first
25 visit so what I would do at the current time which is

2 not ideal is I would send and we do have in, in all
3 of the boroughs at least one site that has the
4 appropriate tables so I would send her to go to see a
5 GYN doctor at one of those sites but I would agree
6 that that's not what's right but there has to be a
7 transition from nothing to what's right.
8 COUNCIL MEMBER AYALA: But then it
9 further exacerbates the wait time, right, so if I am
10 coming in presenting with issues and now, I have to
11 wait to… you know… [cross-talk]
12 MITCHELL KATZ: It could… it could but
13 you would… you wouldn't generally do it on a… [cross-
14 talk]
15 COUNCIL MEMBER AYALA: I just… out of
16 curiosity why wouldn't you give a gynecologist… a
17 gynecological exam on the first visit?
18 MITCHELL KATZ: I'm not saying you never
19 would, I said this, this is a primary care provider
20 that usually… though I would say if the woman's
21 complaint was vaginitis but if the woman's complaint
22 is… which is the typical primary care I'm here for a
23 physical usually because of the set up its visit two
24 and also most of us ask because it becomes a cultural
25

issue some people want… some women want the GYN exam done by a gynecologist not by a primary care doctor.

COUNCIL MEMBER AYALA: Okay… [cross-talk]

MITCHELL KATZ: So, we… it's usually a second visit issue but not if that's their… not if that's their complaint.

COUNCIL MEMBER AYALA: Yeah. No, I under… I, I… [cross-talk]

MITCHELL KATZ: That would be different.

COUNCIL MEMBER AYALA: …would hope that a gynecologist would be able to perform an exam on the… on the day that I show up and not have two… [cross-talk]

MITCHELL KATZ: If you went to a… [cross-talk]

COUNCIL MEMBER AYALA: …different… [cross-talk]

MITCHELL KATZ: I, I was saying if you… if you went… if your first visit was to a primary care doctor but yes, if you set an appointment… [cross-talk]

COUNCIL MEMBER AYALA: I'm just a… I'm just… no, I, I ask because you mentioned that, you know you wouldn't… you wouldn't personally do it.

2 MITCHELL KATZ: Right, as a primary care
3 doctor I'd do it on the second visit unless the
4 complaint was a, a vaginal complaint or pelvic
5 complaint.
6 COUNCIL MEMBER AYALA: Okay, I appreciate
7 it.
8 MITCHELL KATZ: Thank you… [cross-talk]
9 COUNCIL MEMBER AYALA: Thank you so much.
10 CHAIRPERSON RIVERA: Thank you, I want to
11 acknowledge Council Member Maisel, Council Member
12 Moya.
13 COUNCIL MEMBER MOYA: Thank you Madame
14 Chairwoman, thank you Doctor, thank you for being
15 here. I, I just… I'm, I'm sorry if I missed it but
16 when you were going over the specialty care that is
17 being provided throughout H and H was cancer
18 mentioned in that at all or…
19 MATT SIEGLER: Not on the wait times list
20 but we do provide cancer services across the board.
21 COUNCIL MEMBER MOYA: Okay, well the
22 reason why I ask is, you know luckily, you know
23 Elmhurst has went through their kind of legislative
24 priorities and this was last week but when we're
25 seeing a lot of sort of the cancer rates increase

2 especially in immigrant communities when they were
3 defined as where the clusters really come in from,
4 where it's… people from Asia, South and Central
5 America, different parts of, of, of Africa, you know
6 that's the base of the majority of patient population
7 in, in most of these H and H facilities so the reason
8 why I was asking is that since there's… they, they've
9 been seeing an increase and, and most of the time the
10 patients they… that come into an H and H facility its
11 almost when they're, they're terminal, right and it's
12 because… I, I… and I know that you're doing a lot to
13 really start providing the care that's outside of the
14 facilities but just my question was has this… is this
15 something that is… you've seen throughout the H and H
16 system where there's more immigrant communities
17 coming in with high indices of cancer rates?
18 MITCHELL KATZ: I think in general cancer
19 rates are up sir as… just as you're saying and I'm
20 not… I can't answer whether they're up higher in
21 immigrant versus born here because they're up… I know
22 they're up across the board, I think that it's
23 changes in how people are eating, changes in the
24 environment and maybe a little bit that people are
25 living longer and cancer is a disease that… who's

1

2 incidents grows as you age so I think the combination
3 of environment plus older is resulting in generally
4 more, more cancer and it, it also is a challenge when
5 someone gets a cancer diagnosis of course they want
6 to know right… they want to be seen by the oncologist
7 right away as any of us would… [cross-talk]

8 COUNCIL MEMBER MOYA: Correct… [cross-
9 talk]

10 MITCHELL KATZ: …just to understand
11 prognosis… [cross-talk]

12 COUNCIL MEMBER MOYA: Right… [cross-talk]

13 MITCHELL KATZ: …so even if the treatment
14 doesn't need to be that day for psychological reasons
15 you want to try to get them in that day.

16 COUNCIL MEMBER MOYA: And, and… so, but
17 you're saying that there hasn't been an increase in
18 wait time for…

19 MITCHELL KATZ: I don't think that there…
20 that there has been an increase in wait time, I do
21 think several of our facilities including Elmhurst
22 and Bellevue are particularly good at cancer care,
23 have… [cross-talk]

24 COUNCIL MEMBER MOYA: Yes… [cross-talk]

25

1

2 MITCHELL KATZ: …you know very advanced
3 levels of care but like everything else there's room
4 for improvement… [cross-talk]
5 COUNCIL MEMBER MOYA: Right… [cross-talk]
6 MITCHELL KATZ: …and cancer care is
7 another one where there's not uniformity in opinion
8 in the field of medicine to the extent to which you
9 should go specialization versus generalist.
10 COUNCIL MEMBER MOYA: Yeah.
11 MITCHELL KATZ: You know should you… you
12 know should you… there are… there are people who
13 would say a system like ours should have like two
14 cancer centers and everybody should go to them
15 because that's how you get the sub, sub, sub
16 specialty which increasingly cancer care requires. On
17 the other hand you know then people have to travel
18 and cancer visits are not usually one visit, right,
19 it's not like going to the urologist, right, usually
20 people especially if they need chemo are going to
21 need multiple ones so that's where we say well then
22 we… we're going to try to have it in multiple places
23 but again it can be… cancer can be so specific
24 increasingly oncologists are doing one type of
25

2 cancer. Again, very different than when I trained…
3 [cross-talk]
4 COUNCIL MEMBER MOYA: Right… [cross-talk]
5 MITCHELL KATZ: …right where… so, you
6 know so now, you know even specialty times can be
7 effected like okay, you have a great GI cancer person
8 but you don't have a great breast or vice versa at
9 one place and, you know do you move the person, do
10 you move the doctor it's not so easy.
11 COUNCIL MEMBER MOYA: Right, yeah… well
12 that's what I was trying to get at, it's, it's… you
13 know how, how are we examining this, you know
14 holistically as an entire H and H system given what
15 you've just outlined but to add to that and this is
16 my last question Madame Chair, it… given that it's
17 high immigrant communities that are there, are there
18 specific materials that have been made to give in the
19 different languages, I mean I know Elmhurst has all
20 of that and, and they do a great job but I'm just
21 saying as, as a whole is there the materials,
22 translators because you know obviously… [cross-talk]
23 MITCHELL KATZ: Sure… [cross-talk]
24 COUNCIL MEMBER MOYA: …cancer is a… is a…
25 [cross-talk]

2 MITCHELL KATZ: Sure. Well I can say
3 without question that New York City not that its
4 perfect does a better job with translation than
5 either of the two public systems I've previously
6 worked for and that… nothing because of my efforts,
7 that was here and then I think New York City just
8 does better, more… again not perfect, nothing's,
9 nothing in life is perfect but, but more translators,
10 more materials correctly translated, more, more
11 materials, more languages, I think that, that
12 language is one of the things that Health and
13 Hospitals does quite well and again nothing because
14 of my efforts.
15 COUNCIL MEMBER MOYA: Right, well thank
16 you very much.
17 MITCHELL KATZ: Thank you.
18 COUNCIL MEMBER MOYA: Thank you, thank
19 you Madame Chair.
20 CHAIRPERSON RIVERA: I want to
21 acknowledge Council Member Reynoso, thanks for being
22 here. So, I wanted to just ask… just follow up on
23 Council Member Moya's question, how many H and H
24 doctors speak a language other than English and how
25 many staff?

MITCHELL KATZ: Well I do…

CHAIRPERSON RIVERA: Well I know you speak Spanish… [cross-talk]

MITCHELL KATZ: …but I don't know how many do… [cross-talk]

CHAIRPERSON RIVERA: …be everywhere… [cross-talk]

MITCHELL KATZ: Do we know?

DAVE CHOKSHI: I don't know that number off the top of my head, no. I, I personally do as well and I practice but, but I'm not sure what that overall number is.

MITCHELL KATZ: We do… and, and I'll… again to relate to this we… so, again at Gouverneur a third of the people… patients who come to me speak English, a third speak Spanish and I can do, a third speak mandarin and I can't really do more than hello but super good phone translation services always instantly there, never wait more than 15 seconds, very competent, you know my patients like it, I've never had a medical issue where they didn't… where they couldn't do it and we, we have that for all languages everywhere so, I mean I think culturally one of the things I love about Health and Hospitals

2 is a lot of our physicians are from the community,
3 one of the coolest examples is at Harlem we have a
4 brother and sister who are from West Africa both of
5 them are OBGYN, practicing at Harlem where there’s
6 this conclave of West Africans and it’s beautiful,
7 right, I mean it’s everything you would want in
8 culturally competent care, it isn’t always so great,
9 right and we do have mismatches but pretty good I
10 think compared to other public systems.
11 CHAIRPERSON RIVERA: So, there aren’t
12 always interpreters available and I know in Council
13 Member Moya’s district Elm… well Elmhurst there’s
14 over 100 languages spoken inside… [cross-talk]
15 MITCHELL KATZ: Right… [cross-talk]
16 CHAIRPERSON RIVERA: …that facility but
17 you always… you feel like at least the phone system
18 is consistently ready and, and… [cross-talk]
19 MITCHELL KATZ: Consistently… [cross-
20 talk]
21 CHAIRPERSON RIVERA: …we can go in 15
22 seconds.
23 MITCHELL KATZ: Consistently and, and
24 I’ll also tell you and before I worked for a high
25 functioning… with the phone system I wouldn’t have

2 said this, in many ways it's preferable to have phone
3 than in person translators because it allows you more
4 the typical doctor, patient relationship, the patient
5 looks at you instead of the person you look at them
6 and, and it's like in the background it's like
7 reading subtitles, after a while you forget that
8 you're not understanding their mandarin and they're
9 not understanding you where we really value in person
10 translators are for tough hospital issues like end of
11 life discussions, right, you wouldn't… you wouldn't
12 have an end of life discussion ideally with a phone
13 translator, right, there are certain, you know very
14 serious issues where that has to be done in person
15 but again compared to other public systems I've
16 worked in the access is better here.
17 CHAIRPERSON RIVERA: When you're giving a
18 patient news, for example if, if they… if they need
19 to come in for treatment for some sort of cancer I
20 understand that's multiple visits but let's say if
21 someone comes in and they aren't able to be seen at
22 that facility because of your capacity, you aren't
23 able to serve someone who is obese for certain MRI or
24 whatever service it is and let's say you, you refer
25

2 them to another facility, do you charge them for two
3 visits?
4 MITCHELL KATZ: If all you did was refer,
5 no, often though like in the example… you may see
6 somebody once, like when… so, one… an example… the
7 specific… when I saw someone who needed an open MRI
8 she had a visit with me, I mean it was all Medicaid
9 but we, we did send a bill to Medicaid for my visit
10 and then she went to the open MRI and the open MRI
11 sent a, a bill to Medicaid so, it, it depends how…
12 but I understand if you provide no service there
13 should be no bill, if you provide a service then… and
14 then there should be a bill.
15 CHAIRPERSON RIVERA: Right, so that was…
16 that was my question so, I want to ask about costs
17 and missed appointments, do you know how many
18 appointments result in patient no shows and why do
19 you think patients miss their appointments?
20 MITCHELL KATZ: Do you want to… I, I
21 don’t know that we have an official percentage, in
22 many cases its quite high, it can be… I know of
23 clinics in our system where it’s as high as 40
24 percent, our patients often live lives where they
25 won’t get paid if they take off from work, where they

2 may not have transportation, where a kid may get sick
3 or a parent may not be able to be left, they don’t
4 necessarily have the kind of jobs that we’re lucky
5 enough to have where you tell your supervisor I have
6 to go for an eye appointment at 2:30 and your
7 supervisor says good luck, hope that eye appointment
8 goes well…
9 CHAIRPERSON RIVERA: Well does H and H
10 lose revenue with missed appointments?
11 MITCHELL KATZ: We… [cross-talk]
12 CHAIRPERSON RIVERA: Or does that range
13 by… [cross-talk]
14 MITCHELL KATZ: …do… [cross-talk]
15 CHAIRPERSON RIVERA: …specialty care…
16 [cross-talk]
17 MITCHELL KATZ: We do if we don’t
18 overbook, we attempt and it’s a mixed thing, we
19 attempt like the airlines to overbook but get the
20 right number of people so every clinic should and
21 this is the same as you would do in the private
22 sector, right, if you… if the right number of people
23 to see is ten and you have a 20 percent no show rate
24 you would book 12 and then you wouldn’t lose revenue,
25 the problem is if the 20 percent or whatever your no

show rate is just an average and that means sometimes everybody is going to come and you… then you have 12 patients and people are going to wait too long and the doctor is going to get frustrated and then at other times eight people are going to show and you're going to lose revenue. We are trying like other systems and we made a lot of progress of this in LA, calling people the night before, confirming appointments, doing eligibility and pre-authorization all of those things should happen before the person arrives which will also make their visit much better. Bellevue in particular historically people wait a long time, too long for the registration process that's not right, we got up in LA to 90 percent of people were registered for their visit the night before.

CHAIRPERSON RIVERA: And you try to do the reminders in their language of choice… [cross-talk]

MITCHELL KATZ: Of course… [cross-talk]

CHAIRPERSON RIVERA: …right and… [cross-talk]

MITCHELL KATZ: But again, that we're good at.

2 CHAIRPERSON RIVERA: The… and so for the
3 Epic system which we haven't talked a lot about is
4 that going to be a feature that sort of reminder and
5 also maybe a link if they're… if they're comfortable
6 digitally to start the registration process?
7 MITCHELL KATZ: Yes, Epic will help with
8 that, Epic will also help us to see what the waiting
9 time is in nearby hospitals so that you can… and be
10 able to schedule somebody. A, a major issue that I
11 referred to in my testimony is let's say somebody
12 comes right now to the emergency room on a Saturday,
13 they need a specialty visit follow up that week, well
14 the specialty clinic isn't open that week and the
15 emergency room can't see the schedule that's where
16 they then give them the appointment that isn't really
17 an appointment and they just say go to orthopedic
18 clinic at nine a.m. on Tuesday and that then leads to
19 really long wait times. Under the Epic system we'll
20 actually be able to see the, the clerk, the ED will
21 be able to see what the schedule is in orthopedic
22 clinic and put the person into a real appointment
23 instead of telling them to come at nine o'clock and
24 that will be a huge boom.
25

2 CHAIRPERSON RIVERA: Last week we set
3 down with a, a number of people from H and H and we
4 discussed the new facilities that are going to be
5 opening up, brand new, tens of thousands of square
6 feet, they sound like they're going to be amazing,
7 are, are those going to help address the specialty
8 care and wait times?
9 MITCHELL KATZ: Yes, because we envision
10 them as one stop shops so that we're going to have
11 more services than your standard primary care and
12 that will make a difference. So… especially things
13 that go really well with primary care ophthalmology,
14 there's a very high number of people who need eye
15 appointments including all diabetics yearly;
16 podiatry; dental, so those things absolutely.
17 CHAIRPERSON RIVERA: So, are… does H and
18 H plan to open more new facilities to address
19 specialty care needs?
20 MITCHELL KATZ: Well I think we'd open up
21 new facilities for the mix of primary and specialty
22 not, not just for specialty but yes, I mean I don't
23 want to oversell that space is not our major
24 limitation for specialty, it's, it's really the
25 doctor in the right place in these, these micro

2 climates of things used to be great because you had
3 two and now one has left and in that three months
4 until you hire the new one the wait time gets
5 astronomical and nobody knows how to move the person
6 to the other clinics so I am trying and I think we're
7 making some progress to get Health and Hospitals to
8 see itself as a system to help one another so a
9 patient, you know needs an appointment and your
10 facility doesn't have it send them to another
11 facility.
12 CHAIRPERSON RIVERA: So, in my testimony
13 I mentioned that we had a joint Committee hearing
14 with Health about TGNC and B New Yorkers and so just
15 really briefly is there any update on, on… from that
16 hearing in terms of… you mentioned… you mentioned
17 metropolitan hospital which is a great program, are
18 there any plans to I guess expand those services or,
19 or kind of replicate them in other facilities?
20 MITCHELL KATZ: So, yes, I mean I don't
21 have detailed information but it's, it's certainly a
22 need that people value, we do… we certify our
23 providers on trans gender care, we have a really good
24 online module which I've taken and gotten certified,
25 we have a number of providers who are competent to

2 prescribe hormone treatments and it's an area where I
3 think H and H does well but there's more to do, more
4 that could be done.
5 CHAIRPERSON RIVERA: And I know that you
6 have… will likely have a hearing, a focus on Epic and
7 the rollout and I know that you're doing a tremendous
8 amount of work to consolidate this… that system and
9 how it's working in silos and individual facilities
10 and so that should be exciting. A quick question on
11 eConsult, is H and H tracking patient satisfaction in
12 regard to the use of eConsult?
13 DAVE CHOKSHI: We, we are, we've started
14 by doing some, some surveys of patients, you know
15 related to the normal patient satisfaction surveys
16 that, that we do for all Health and Hospital's
17 patients and we're also collaborating with some
18 external partners who have experience in the academic
19 setting to do a more formal rigorous evaluation that
20 will capture patient satisfaction, provider
21 satisfaction, as well as, you know some of the
22 measures that we've talked about in terms of reducing
23 wait times.
24 CHAIRPERSON RIVERA: Have you seen an
25 increase in, in patients since NYC Care was announced

2 by any chance? I know the rollout is not complete,
3 I'm just curious as to whether people heard that and
4 they kind of… [cross-talk]
5 MITCHELL KATZ: We've gotten some calls
6 but no, I mean not a detective… remember we're a huge
7 system so it's hard to… it's hard to see major
8 changes when we see a million patients a year.
9 CHAIRPERSON RIVERA: So, I'm… well I'm
10 going to ask some of the advocates of course about…
11 [cross-talk]
12 MITCHELL KATZ: Of course… [cross-talk]
13 CHAIRPERSON RIVERA: …like Epic and about
14 eConsult, excuse me and about some of the other
15 issues that we spoke about today. I, I did want to
16 just of course thank you for always being here and,
17 and answering our questions to the best of your
18 ability. I think with the, the appointment system and
19 Epic and kind of this, this technology upgrade that I
20 think you all desperately need it will certainly make
21 a difference and in terms of some of the things that,
22 that my colleague like Council Member Ayala spoke of
23 in terms of people with disabilities and that access,
24 you know I, I don't… I don't want… I think a clearly
25 smart design and sometimes it could be one little

2 thing that’s short sighted so I appreciate you
3 bringing up kind of this recognition that even in
4 something that seems to be right there is something
5 that is just not thoughtful in terms of people and
6 their limitations so if there are issues with
7 something like tables, you know I hope that’s
8 something that we can work on together because…
9 [cross-talk]
10 MITCHELL KATZ: Great… [cross-talk]
11 CHAIRPERSON RIVERA: …I realize that the
12 Mayor is totally invested in H and H in terms of the
13 money that, that is allocated but I, I do think there
14 are some things that, that are a little short and I
15 think that there are certainly things that, that we
16 have funded recently that I would think… I, I would
17 never have thought that an EKG machine would have to…
18 something that we would have to fund but if that’s
19 the case you have to… please let us know… [cross-
20 talk]
21 MITCHELL KATZ: Thank you… [cross-talk]
22 CHAIRPERSON RIVERA: …we want to be
23 helpful, we want every facility to be able to take
24 care of as many New Yorkers as possible whether it’s…
25 you know regardless of gender or, or you know

limitations, so we certainly want to be helpful. And I guess with that I don't have any further questions and, and thank you… [cross-talk]

MITCHELL KATZ: Thank you… [cross-talk]

CHAIRPERSON RIVERA: Thanks to all of you. Okay, so I'm going to ask the next panel to please come up; Oliver Gray, Associate Director of DC 37, are you… okay, great; Anne Bove from CPHS and NYSNA and Heidi Siegfried from CIDNY.

[off mic dialogue]

CHAIRPERSON RIVERA: And Anthony Feliciano from Commission on Public Health Systems. Mr. Feliciano you have filled out a sheet, correct? Okay, excellent. So, okay great. Is there anyone that would like to begin? Okay, thanks, thanks, thanks Anne.

ANNE BOVE: Okay, my name is Anne Bove, I'm on the Board of Directors for NYSNA as well as CPHS. And in terms of specialties one of the documents that I passed out just now deals with funding because most of this is nice to talk about but if you don't have the dollars behind it it's not going to happen and the indigent care pool as part of the Governor's budget really is, is… you know

2 instrumental in terms of getting a lot of these
3 services there and in terms of whatever City Council
4 can do to help that would be greatly appreciated. But
5 in terms of looking at specialty services, I worked
6 as a registered nurse at Bellevue Hospital for 40
7 years, I just retired about a year ago… a year and a
8 half ago and one of the things that H and H does is
9 it does level one trauma and with level one trauma
10 you need to have all the specialties and in order to
11 have all the specialties you need to have funding
12 behind it to provide all the specialties but those
13 specialties are there from an emergent framework not
14 an urgent framework in terms of looking at it from a
15 secondary treatment modality. So, subsequently you
16 know in terms of the availability of resources, in
17 terms of personnel, doctors, nurses that's where the
18 limitations lie. And you also have to look at how the
19 distribution of services is happening now. For
20 example, at Woodhull Hospital in Brooklyn a lot of
21 pop up clinics are showing up from the, the different
22 networks like Northwell, Mount Sinai as examples and
23 what's happening now is, is that they're basically
24 taking the patients that would have normally gone to
25 Woodhull because of wait time and subsequently are

2 providing services to then transport those
3 individuals for whatever that specialty is that they
4 need. In terms of looking at for example, Bellevue
5 Hospital, there's also services that are just
6 provided by NYU that, you know that haven't been
7 really advanced or, you know built up within Bellevue
8 Hospital and I could tell you more in, in, in regards
9 to that but the idea is, is that is H and H
10 supplementing the affiliates in terms of them
11 handpicking what patient population would get the
12 best reimbursement for them. I know for example at
13 the VA because I work there on weekends, they… there
14 are certain services not provided by the Manhattan VA
15 and the patients are transferred to NYU for those
16 services so there's reimbursement that act… that
17 comes accordingly and as… is definitely there because
18 these individuals are veterans so subsequently
19 there's money there. In, in regards to looking at the
20 different specialties available, one of the problems,
21 what was brought up about bariatrics in terms of the
22 obesity framework issues that we have in the city…
23 in… not… nationwide right now, a lot has to do with
24 the fact that the end user, the clinician is not
25 involved and the patient population is not involved

2 in the architecture or the setting up of, of, of the
3 building… of the services so, you know you… what's
4 really needed is the end user to be there not people
5 in an office and then you come… I mean we have new
6 ICUs built at Bellevue about… now about 12 years ago,
7 12, 14 years ago but when they first opened up, I
8 mean things like the door couldn't open all the way
9 in the bathroom because it hit the toilet so then it
10 had to be restructured, you know stretchers couldn't
11 fit in, in the HIV clinic so it had to be, you know
12 reconstructed, you know and so I think that part of
13 the issue is, is that we need to be looking at the
14 end user and the reason an epic hasn't hit the
15 Veteran's Administration is, is because it's not ADA
16 approved, it doesn't meet the… meet the full
17 criteria. So, when you're talking about people that
18 are… you know if you talk about digital registration
19 you also have to have… make sure that those
20 individuals first of all have access to digital
21 registration, you know do they have access, is this
22 something that could be an app on a phone and what
23 percentage of people actually have the ability to
24 have that phone and that app. So, in, in regards to
25 looking at specialty services and looking at the

2 availability I think, you know once again what was
3 spoken about was the idea of looking at the, the
4 demographics of the different areas and seeing, you
5 know where you have certain entities that need to be
6 focused on and to provide those services in a way
7 that are reasonable and accessible and what's most
8 important is to have and it may sound simplistic but
9 I can't overemphasize it, the idea of having the end
10 user involved. The other thing with Epic, I, I mean
11 it… this may be off topic but I don't think it really
12 is, is Epic also demands that you use certain
13 company's equipment so that you have to use a certain
14 infusion pump, you have to use a certain bed side
15 monitor, you have to use a certain etcetera, I could
16 go down the line so then is this a monopoly, you know
17 and then I also worry about if, if Epic is being used
18 throughout the corporation most of our affiliates,
19 most of the networks in this area also use that and
20 is that going to be a tool, if you're going to look
21 at how long people have to wait for an appointment
22 are our affiliates going to then use that as a
23 mechanism once again to then, you know take those
24 people that have the insurance. What I worry about
25 is, is that, you know with this present federal

2 administration in terms of public benefits if those
3 become much restricted and then the resources that we
4 have in H and H limited and then those, those
5 patients are no longer being able to see… be seen in
6 the voluntary or private sector what's going to be
7 available for them. So, I think that in terms of
8 looking in that continuum and holding people
9 accountable and getting real statistics and real data
10 collection is vitally important from a third party
11 and that… and that your end user needs to be involved
12 and companies can't or architectural firms can't
13 dictate what needs to be done, Bellevue is supposed
14 to be a bariatric center. If anybody should have an
15 open MRI it should be Bellevue and I'm, I'm… been in
16 the system long enough to remember when they didn't
17 have a CAT scan and we had to send people to NYU. So,
18 it's, it's not acceptable and I'm not saying that
19 MRIs are cheap but the cost effectiveness in terms of
20 that capital budget for purchasing that device way
21 outweighs not, not getting it. So, I guess that's all
22 I have to say for today. Thank you.
23 CHAIRPERSON RIVERA: Thank you. I guess
24 how about Mr. Gray.
25 OLIVER GRAY: Push this button… oh.

CHAIRPERSON RIVERA: Yeah.

OLIVER GRAY: Okay. First of all, let me say I think you're my Council rep.

CHAIRPERSON RIVERA: Where do you live?

OLIVER GRAY: I live on 14th Street in Stuyvesant town… oh, I think we spoke about this once, I think I'm on the wrong side of the street… [cross-talk]

CHAIRPERSON RIVERA: You're… I wasn't going to say you're on the wrong side, yeah, if you moved across the street then I'll be your Council Member, you'll be in great shape.

OLIVER GRAY: Yeah, well, well… [cross-talk]

CHAIRPERSON RIVERA: Oh, I love Keith Powers of course.

OLIVER GRAY: Maybe I'll do that but… I, I remember you were running, and you came out of the church on the corner near first and 14th, okay but at any rate…

CHAIRPERSON RIVERA: Good to see you again.

OLIVER GRAY: Good to see you. I worked with Health and Hospitals for six maybe years, I also

2 had the experience of working here at the Council for
3 a number of years but at any rate. Good afternoon and
4 I want to thank you for the opportunity to testify.
5 I'm going to touch on a number of areas but in a more
6 general sense where ultimately if we go much further,
7 we'll be back to testify on legislative initiatives
8 from the Council or from the union side. What's very
9 important is this that our union represents 18,000
10 workers in the H and H system. I… sometimes I'll slip
11 and call it HAC but it's H and H and we recognize
12 that with more than a million visits in all types of
13 facilities that there's quite a bit of effort on our
14 part so there's some issues that are very important
15 to us. We recognize the fact that we handle a
16 significant if not most of the indigent care
17 population in the city. Now what that means is that
18 no matter what's said at the end of the day if a
19 person can't get their health care somewhere else
20 the, the, the… H and H becomes the… almost the family
21 physician which at times is not the best thing in the
22 world but at any rate the good thing that I can say
23 is that generally we feel that H and H is becoming a
24 better system and… recently. There were tremendous
25 problems in terms of the funding and the ability to

2 maintain the facilities, today as was indicated the
3 number of new facilities and things coming online
4 including medical… digital record is very important
5 and will serve to make the system more efficient. But
6 at any rate the, the hospitals have had funding
7 problems for years and there were many proposals over
8 the years to close, to downsize, to do a number of
9 things which would have ultimately destroyed the
10 ability to provide care to communities in need and
11 while we always opposed most of those things it's
12 good to see that we now feel that it… there is some
13 serious concern about the nature of the facilities
14 and the programs. A working group convened by the
15 state and the representative stakeholders have
16 evaluated several options and our union endorses the
17 proposal known as the H and H community ICP proposal
18 which would draw down additional federal matching
19 funds through an enhanced Medicaid rate. The
20 hospitals with the large buzz… budgets and taxed you…
21 quite often to prestigious medical schools have such
22 extremely high rates that we are concerned that they…
23 the intent may be to minimize what a system like H
24 and H does so we're encouraging this Council to work
25 with us in support of a proposal which will help us

2 to guarantee what is remaining of the federal monies
3 especially as they apply to what we call the, the
4 indigent population. Single payer systems, there’s,
5 there’s been much discussion in the state and the
6 country about a single payer system or Medicaid…
7 Medicare rather for all system. The number one issue
8 for Americans in the mid term elections of 2018 was
9 indeed health and health care and while we heard from
10 the administration in Washington that they felt the
11 imperative was to reduce, eliminate and destroy we
12 feel that the results of the elections were clear in
13 that they stated that we need to do more in terms of
14 providing health care but we are concerned that some
15 of the proposals on the table will go a long way to
16 undermine some of the things we do. For example, when
17 we negotiate our contracts the health is very much a
18 part of that and it’s very important to us that we
19 maintain the economic viability of those contracts
20 and those services. Primary specialty care, our union
21 is strongly in support of the proposal to invest 100
22 million dollars in H and H in order to provide the
23 critical primary care and specialty care to New
24 Yorkers regardless of their insurance or immigration
25 status. We want our neighbors, our fellow workers and

2 passengers on the subways and buses to be healthy.
3 Some of us are fortunate to have private health
4 insurance through our jobs including the excellent
5 plans available to city workers. However, more than
6 600,000 New Yorkers and their family are still
7 uninsured and it’s possible they are not able to
8 access insurance despite many programs that exist. We
9 cannot leave these people out of the health care
10 system, if we do it creates a weak link in the chain
11 of a strong city. With additional funding more
12 primary care doctors and health care providers will
13 be added to the system, more ambulatory care clinics
14 can be opened in convenient locations with extended
15 hours to meet the needs of the patients. And three
16 express care clinics; Elmhurst, Lincoln and Jacobi in
17 the Bronx have been implemented recently with
18 extended hours and the fact that their ability to
19 absorb patients is even greater. With all of the
20 expansion comes the additional need of clerical and
21 clinical support staff, these are good jobs with
22 benefits that provide additional stable employment in
23 the community. specialty care, well you know what I
24 think what I’m going to do is to leave the remaining
25 items here for you to read but the basis is that we

2 believe that a strong viable H and H system is indeed
3 a system that has to be maintained. It is the system
4 quite often of last resort for many families and if
5 what we're hearing is correct coming out of
6 Washington then ultimately it may indeed assume an
7 even greater role going into the future. Thank you.
8 HEIDI SIEGFRIED: Okay. Hi, I'm Heidi
9 Siegfried, I'm the Health Policy Director at Center
10 for Independence of the Disabled in New York and we…
11 our goal is to ensure full integration and
12 independence and equal opportunity for all people
13 with disabilities by removing barriers to full
14 participation in the community. So, we help people
15 with disabilities of all kinds understand, enroll in
16 their insurance and use it and in their… and get
17 care, get access to the care that they need. I… like
18 we, we don't… haven't heard any particular complaints
19 and I don't have any expertise really about specialty
20 care at H and H, but this has been really
21 interesting. I do… I have done a lot of work on
22 network adequacy and held focus groups all around the
23 state at… and the, the appointment availability time
24 issue is, is a big one so it was interesting to hear
25 this new, new data. In New York for, for network

2 adequacy we have 30 minutes, 30 miles requirement and
3 then in Medicaid we have appointment availability
4 times depending on the type of appointment that you
5 need to get so it's like 72 hours for one type of
6 appointment and four weeks for another type of
7 appointment and so these are all… you know the
8 Department of Health maintains these, these standards
9 for Medicaid but when IPRO goes out to do a secret
10 shopper audit of the Medicaid plans they find that
11 just about every… I think they do it every two years
12 and the most recent one that I saw they all failed.
13 So, that meant that they were not able to meet those
14 appointment availability times 75 percent of the
15 time. So, I'm really… I'm… I've been pushing at the
16 state level with our state agenda to, to have
17 appointment availability times for all types of
18 coverage and, and to have some enforcement somehow,
19 you know because that's really the problem, I mean
20 you know they… so, Department of Health gets these
21 reports, do they do anything about it, you know we
22 don't really know because they're not the most
23 transparent organization but… so, I'll just say that
24 I decided to focus my remarks more on access issues
25 because that's really important, that is something

2 that we work on at CIDNY and people with disabilities
3 tend to get overlooked because they're just sort of
4 thought of as this small population that people don't
5 think about like, you know for example, they don't
6 think about it when they put in a towel holder in a
7 bathroom but… so, I just… I did put some data there
8 about the percentage of New Yorkers that have
9 different types of disabilities; visual, hearing so
10 we're not just talking about ambulatory disabilities,
11 you know cognitive, self-care and independent living
12 and the reason why it's important to have access to
13 care… I mean people with disabilities are recognized
14 health disparity population in the affordable care
15 act and you know the reason is because they often go
16 without care because of the accessibility issue.
17 They're more likely not to of had a dental visit in
18 two years, a mammogram in two years, a pap… oh,
19 dental visit in a year I think it was, annual, yeah,
20 a pap test within three years and, and there is this…
21 there is an interaction of factors that includes, you
22 know discrimination, accessibility and accommodation.
23 So, it's not… it's not really just the physical
24 accessibility it's also programmatic accessibility
25 because we often think oh well that's just talks

2 about ramps and adjustable tables and, and weight
3 scales but also it, it's accommodating people by
4 giving them… you know certain appointment times like
5 maybe if they're on some kind of metal health drug
6 that they don't really function too well until later
7 in the day or… and you know not to have… to get
8 additional help when they need it filling out forms,
9 if they have a cognitive problem and then of course
10 communication, American sign language needs to be
11 available and you know that kind of thing. And I will
12 say this is another issue where in New York State we
13 don't… we don't have any kind of… we have like very
14 lax rules about accessibility even for the… for the
15 physical accessibility because we allow self-
16 attestation so the, the providers they don't even
17 know really what an ADA compliant facility is but
18 they think that they are and so we… you know we don't
19 really… we don't have a third party going out and
20 testing it and in California they have… they have
21 done this, they've worked actually with Syracuse
22 University which is in New York State and with DREDF
23 which is the Disability Rights and Education Defense
24 Fund and you know they've used a, a, a survey tool
25 that has, you know 86 items on it and they have… you

2 know they have found some improvement, they've only…
3 they've only surveyed primary care offices but just
4 that… and it… and it's still really low but by, by
5 measuring… you know whatever you measure you get
6 improvement in, right and so they did go from height
7 adjustable exam tables, went from 8.4 percent in 2010
8 to 19 percent in 2017 and adjustable… and accessible
9 weight scales went from 3.6 percent to 10.9 percent.
10 So, it's just… and we don't really… I, I don't have…
11 it's interesting because we, we have this United
12 States access board that develops standards for
13 accessibility and they went through developing the
14 standards during the Obama Administration of what an
15 accessible exam table would be so they are talking
16 about does it go to 17 inches, does it go to 19
17 inches, I mean they were having arguments about this
18 type of thing but then the next phase was supposed to
19 be well what percentage of providers do you need to
20 have that, that have accessible exam tables or, or
21 diagnostic equipment and that was when of course the
22 new administration came in and, and shut… they shut
23 down that next piece of work so I can't really say,
24 you know what is an acceptable amount of offices but
25 certainly, you know one in each borough is… isn't you

2 know what we'd like to see and we need to… we… it
3 would be good to just really do a good survey and,
4 and see what we have and try to improve it.
5 ANTHONY FELICIANO: Good afternoon. My
6 name is Anthony Feliciano, I'm the Director of the
7 Commission on the Public's Health System. I concur
8 with my colleagues here, but I want to touch on some
9 other factors related to specialty care and thank you
10 Council Member Carlina Rivera and Council Member
11 Diana Ayala. We kind of know access to specialty care
12 in New York City safety net is already strained, it's
13 already facing increasing pressure with cuts to
14 health care at all levels of government and some of
15 this I will not go through it but obviously it goes
16 to the issue of a specialties gap down to
17 underrepresentation of minorities, communities of
18 color, immigrant communities, ethnic communities
19 within those fields as well. Although I agree with
20 Dr. Katz that, that there are a lot more diversity in
21 terms of physicians and all that and, and nurses in,
22 in the health care… in the hospital system in terms
23 of the public hospitals. But we know that we have a
24 unique landscape, right, we're the… we have the
25 largest public hospital system in the nation but we

2 also have the most prominent academic medical centers
3 in the nation and that’s caused a real two tier
4 system whereabout you see low income patients who are
5 publicly insured, Medicaid or uninsured or
6 underinsured disproportionately receiving care in
7 public systems while privately insured patients are
8 overrepresented in the private hospitals and really
9 what basically it is, is that you see this varying in
10 equitability also in specialty care and part of it is
11 and I’ll explain a little bit more about that, its
12 also the cost of specialty care varies within
13 hospitals and hospital networks and so that’s a big
14 issue too but when you think about public hospitals
15 it’s also community health centers and other true
16 safety nets they have assumed the responsibility for,
17 for a greater proportion of the care of the uninsured
18 and for marginalized communities but we still need to
19 be concerned at the capacity for these safety net
20 providers especially Health and Hospitals to care for
21 them, is always in jeopardy especially for specialty
22 care or diagnostic testing. In addition this is why
23 we can’t look at Health and Hospitals just in a
24 vacuum ,the ability to provide specialty care must be
25 looked at from a comprehensive lens particularly

around the inequity and the segregated health care system in terms of how that's distributed and who has access and in private hospitals to be frank can't survive without public hospitals, accepting patients at all levels. This reality determines… means that we really have to correct inequity and that's why I say about looking at specialty care from a, a much broader view. In November, 2018, Health and Hospitals announced the expansion of the eConsult system, you know as a tool that makes it easier for primary care providers and specialist to communicate with each other helping the patient and sometime in 2019 we're going to have New York Cares which begins to guarantee some more comprehensive health care for all residents particularly specialty care, prescription drugs, mental health services and hospitalization. But I would say to the City Council Hospital Committee and individual Council Members where the public hospitals there… are located in their districts to really closely monitor and get updates on these implementations. We support these efforts but we also understand maintaining, sustaining capacity including staff in the public hospital system to fulfil it's mission and provide to both

2 residents and adjacent communities as well continue
3 to be a challenge and we know that we still need to
4 fix various areas that impact access to specialty
5 care and other forms of medical care. While I don’t
6 have all the data on Health and Hospitals delivery of
7 specialty care, I do have stories and issues and
8 concerns. Major issues for us is still waiting times,
9 referral delays, the call center, some of it is also
10 what Anne had alluded to and said about… and so, so
11 the other concern is also… we know H and H efforts to
12 insure everyone is an important goal, they’ve done
13 well and, and they do well with it but certain
14 facilities what I heard have been a little bit
15 coercive in steering away people if they don’t fit in
16 the pre-certified status of health insurance,
17 steering them away from some HAC options. I don’t
18 think that’s across the board but that really needs
19 to be addressed. Particularly when we know that a lot
20 of immigrants still fear given the federal threats,
21 through public charge or through ICE being at courts
22 or at the front of hospitals there’s still that fear…
23 still aligns and so even when the person is publicly
24 insurable they may have a family that’s not and that
25 person may not choose to go on Medicaid or private

2 health insurance because of that fear. So, I have
3 some recommendations. I think the most obvious and I
4 think H and H does well of it in times and sometimes
5 not always but way better than the privates is to
6 insure that community based organizations are
7 directly involved in conducting outreach, assessments
8 and maximizing their efforts and I think we've done
9 well in the past with H and H but I want to improve
10 on that and make… and strengthen it. patient
11 appointment and scheduling clinics progress, I think
12 there needs to be a clear uniformed definition on
13 measuring access to specialty care. There's a… other
14 ones that I have here bulleted to form a specialty
15 care scheduling committee or something like that to
16 governing body for guiding these things. I think it's
17 also improving daily clinic communication through
18 defining staff roles, creating standards of work for
19 all staff… with the staff as well. I have a whole
20 bunch of other ones here, I also think optimizing
21 eClinicWorks training better with staff but in the
22 end its also ensuring safe staffing around specialty
23 care and all types of clinical care and the City
24 Council I think really should send a letter of
25 support around the safe staffing legislation with

2 NYSNA that has been spearheading it, I think its
3 important to do that, no point of having all this
4 specialty and clinical care and you don't have enough
5 staff to take care of people, that's a… not only a
6 safety issue for the nurses but it's also a patient
7 quality care issue. I think you have to continue
8 engaging front line staff in improvement, you know do
9 daily performance improvement huddles or something
10 like that, institute counter measures to improve
11 specialty and procedural and surgical wait times,
12 monitor weekly wait times as well and so me the
13 current fiscal environment has significantly and
14 negative… have negative consequences to terms of
15 delivering timely and high quality specialty care,
16 providing a positive patient experience, maintaining
17 financial sustainability and satisfying regulatory
18 standards. We want to ensure H and H succeeds in
19 their efforts to improve access and quality of
20 specialty care but it… we know that there are
21 challenges and we really need to address them but
22 it's also not addressing H and H as… on it's own, we
23 have to look at this entire health care system in
24 terms of access to care particularly for the most
25 marginalized communities. Thank you.

2 CHAIRPERSON RIVERA: Thank you, I just
3 wanted to ask a couple of questions if that's okay.
4 So, let me start with the eConsult I know Anthony you
5 mentioned in your testimony, does anyone here have
6 experience with H and H's eConsult system, not
7 personally but… [cross-talk]
8 ANTHONY FELICIANO: My, my mother has so…
9 and it varies depending, you know I, I… is like a… is
10 a tool, right, it's not the end all so it cannot
11 replace the… all the patient and, and doctor
12 relationship or… and things like that, sometimes it
13 works for my mom sometimes it doesn't, I never really
14 got full details but once or twice when she goes
15 Bellevue she feels that it has worked for her and
16 then other times she's literally had decided not to
17 come back because of some situation but my mom is
18 that same person that's living through a very hard
19 condition, has Lupus and many other factors going on
20 and lives in public housing as you know and all these
21 things play a role and so that causes her not to also
22 go to appointments and so that's a clear thing.
23 That's why you have to some gap assessments and
24 really do them with community-based organizations
25 and, and it's not just academics doing it because

2 I've noticed sometimes these surveys don't… are not
3 really culturally competent, don't really connect to
4 communities, that's what the CBOs are for, we're the
5 trusted brokers for that.
6 ANNE BOVE: Sorry, but also with eConsult
7 you… it's a… it's a phone exchange between physician
8 to physician so… or whoever the specialist is; could
9 be an NP I… whatever but, but the point being is, is
10 that there's no visualization of the patient on the
11 part of the other individual so it's not a be all in
12 the end all and the person most likely would still
13 need another consult, it would be like to treat the
14 urgent situation and hopefully that individual would
15 then get an appointment with that actual specialist.
16 I also wanted to bring up a, a couple of things that
17 I forgot to mention, one of the issues is, is that
18 New York City employees all the insurances available
19 to New York City employees should also be accepted by
20 H and H and that's not always the case. For example,
21 I used to… I have… still have GHI but for a long time
22 GHI was not accepted by Health and Hospitals so, you
23 know I would pay the supplement when I would, you
24 know get care that I needed and the other thing is,
25 is that cancer… the idea is your treatment is

2 important but the more important issue is screening
3 and what kind of outreaches are we making to the
4 community to get people screened for cancer because
5 yes, when the person comes in they're going to…
6 they'll get as best care as possible for the stage
7 that they're in but you don't want to see them in
8 their later stages, you want to see them early on in
9 order for obvious reasons and where I always felt
10 that there's an issue is, is that we don't have a
11 catalogue of services and we don't really go out
12 there and toot our own horn so to speak, you know I,
13 I live in Sunny Side Woodside so I see this stuff
14 with Elmhurst, I mean I grew up at Bellevue so that's
15 where I go but, you know the idea is, is I do see
16 some advertisements but not to the level that, you
17 know you would expect in terms of that community. So,
18 and also to know how to navigate the system and see
19 what services are readily available.
20 ANTHONY FELICIANO: When I alluded I
21 talked about segregated care, there's also this issue
22 that there's a perception that our public hospitals
23 don't provide high quality care, for special…
24 especially around specialty care and that's part of
25 what the powerhouses get… bank on as well and I think

2 that… the perception has changed over time but that
3 still gets played out in many ways.
4 CHAIRPERSON RIVERA: Have, have any of
5 you received feedback in terms of people who actually
6 want to access the specialty care so, we know as, as
7 individuals that there is phenomenal care providers
8 at H and H but… however, maybe not any, any one… not
9 everyone necessarily knows that so for those who have
10 entered in H and H system have you had the
11 conversation as to how their access was, was like,
12 what their experience was and specifically I wanted
13 to ask for any clients, you know that have physical
14 limitations their experiences in being in an H and H
15 facility that was ADA compliant in a real way? I know
16 that you mentioned in your testimony Miss Siegfried
17 that you don't have… you haven't received any
18 particular complaints but I think that your, your
19 other recommendation as to an actual survey as… like
20 the one they did in California is, is really, really
21 interesting and so is that just based on the
22 conversations you've had with some of the people at
23 CYDNY in just conversations?
24 HEIDI SIEGFRIED: Well I, I, I asked my
25 executive director if, you know if there was a way to

2 try to find, you know what our CYDNY consumers are
3 experiencing, I mean I probably could ask staff, I
4 mean I don't think there's probably going to be a way
5 to do a query of our consumer records to find
6 anything on this but I could probably do more work
7 to ask staff if they have any complaints from…
8 [cross-talk]
9 CHAIRPERSON RIVERA: Yeah, if it's… if
10 it's appropriate… [cross-talk]
11 HEIDI SIEGFRIED: …you know what their
12 experience has been using an H and H facility and,
13 and getting care if they have a disability, yeah. I
14 could… I could see if I can get some stories.
15 CHAIRPERSON RIVERA: Yeah, I… and of
16 course if it's appropriate and I… and I only think
17 because I, I know that the people at H and H and, and
18 mind you all of them are still here listening, I
19 think they'd welcome that sort of constructive
20 feedback to see how they could improve.
21 ANTHONY FELICIANO: I will concur, I
22 think Katz knows for the time he's been here he's had
23 a lot of CBOs come together and have conversations
24 with him. I think what we need to do a little bit
25 better is get that same information to the council in

2 some ways in terms of stories and all that. I can
3 only give you my mom's situation, you know which has
4 gotten better over time, but you know she will miss
5 an appointment and at… and many times it will be nine
6 months before she gets the next lupus appointment.
7 Now she's in… because of her age it allows her lupus
8 not to be as, as, as strong in her, her system as
9 others if she was younger but just from a clinical
10 standpoint but it… you know that kind of feeling
11 makes her not want to come the next time again
12 because why I'm going to wait nine months again or
13 she'll go in to get… other clinic get her
14 appointments for her heart and everything else and
15 they'll, they'll say well you have to come back to
16 get the appointment like I… and I don't think that's
17 across the board but if that's one person I can
18 guarantee you that the CBOs that we work with have
19 plenty of other ones that are… that have these issues
20 and concerns.
21 CHAIRPERSON RIVERA: And thank you for of
22 course sharing the, the experience of your mom and,
23 and I know Council Member Ayala shared the experience
24 with her dad which I think brought up a good point
25 about Bellevue and being kind of this epicenter and

2 some of the things that they should provide so… and I
3 know that when it comes to members at DC 37, I mean
4 18,000, you know sets of eyeballs, honest situation
5 or experiences in the facilities, you know we welcome
6 also the employee experience as to what they're
7 seeing because you know you're the ones on the
8 ground. So, the Council definitely wants to be
9 helpful, sometimes we are kind of stuck in City Hall
10 and so we certainly welcome those stories and, and we
11 could relay that, clearly you all have the
12 relationship to relay to H and H but sometimes it
13 helps when, when it comes from someone who's
14 representing those particular facilities.
15 ANNE BOVE: I, I have friends that are
16 in the world trade center clinic as patients and the
17 issue was it… they are very satisfied with the care
18 but the issue is getting into the clinic, into the
19 system and accessing it and you know they, they
20 needed some help in terms of navigation in order… in
21 order to get into the clinic so I think it's, it's
22 like once people are in the system generally speaking
23 they're very satisfied with the quality of the
24 providers but it's the idea of being able to
25 navigate and being able to work through it and to

2 understand the process of that navigation and like I
3 said I really don’t think, you know I’m tired of
4 seeing those Columbia Presbyterian advertisements on
5 T.V. because, you know I can tell you ten stories in
6 my lifetime that I’ve seen it… you know for every one
7 they talk about so I really don’t think we… you know
8 the system as itself toots it’s own horn in terms of
9 what it’s capabilities are and, and, and that’s, you
10 know basically what I want… you know but I really
11 think it has to do with the process in terms of the
12 assistance in terms of getting into the clinics, the
13 registration, the access for appointments, etcetera,
14 etcetera and to know how to do that.
15 CHAIRPERSON RIVERA: Right and I… and I
16 try to focus a good amount of time on appointments
17 and the wait times and the new system and… because I
18 think that’s just so important once you get there.
19 ANNE BOVE: There’s also… there’s also
20 clinics that kind of like dovetail each other like
21 your asthma clinic and your GI clinic in terms of,
22 you know GURD and all that, I mean they’re
23 interrelated so that you need to have those kind of
24 clinics working together with each other and
25 available so that you’re not jumping from one area

2 to… from one hospital to another or what have you and
3 I think that also working in concert with regards to
4 those things is also quite important as well.
5 OLIVER GRAY: During my time with H and H
6 and even afterwards I was very much aware that each
7 facility had what they called a community advisory
8 board and what happened too often was the board spent
9 an inordinate amount of time complaining now not to
10 say that there weren't things to complain about but
11 when we talk about the image that's presented of the
12 voluntaries or private, whatever they call themselves
13 if they do it through advertisements and we have our
14 members and our community in the hospital and they're
15 thousands and thousands of transactions every day
16 that result in a satisfactory conclusion we have to
17 find a way to harvest those and get them out to the
18 public and especially those who use the hospitals. I
19 had occasion to use Bellevue on… for a pretty serious
20 matter, I went there, the physician in charge of the
21 emergency room facilitated my entry, didn't know who
22 I was and before I knew it I had a satisfactory
23 conclusion, I wrote a letter to express that, you
24 know I'm not sure that many people would do that but
25 at the same time there must be a way to get people to

2 attest to the fact that these institutions are not
3 what I, I hear people alluding to from time to time,
4 I spend a lot of time defending and saying this is
5 not the place that I know of.
6 CHAIRPERSON RIVERA: No, I, I think
7 that's fair and, and when you mentioned the CABs, the
8 Community Advisory Boards, I just think that we could
9 all still do a little bit of work on how to empower
10 them in a different way because the… that, that board
11 is only as productive as the resources, the
12 individual members have and so I know some of them
13 had some issues even filling the vacancies and I
14 think that was because of a level of frustration in
15 certain facilities with leadership at the time and
16 this was years ago when I was a member of the CAB, of
17 the Bellevue CAB and Anthony you wanted to say
18 something.
19 ANTHONY FELICIANO: Yeah, you know 20
20 years ago CPA did a lot of training to the community…
21 advisory boards, one to understand the charter and
22 understand everything that was going through it, I
23 think that… the, the… I agree with you in terms of
24 resources and thinking that through but also the
25 opportunity that we have is that we still have

2 facilities and, and, and leadership not… per se maybe
3 not in the central office but still across the board
4 in different levels who still act like their own
5 chiefdom, they don't act, act like a network and I
6 know that Katz and others have tried hard to change
7 that behavior but it's still there and it's a work in
8 progress but that's still happening and, and so you
9 know when they… when H and H branded themselves as H
10 and H it was part of that issue and that… and then
11 I'll give you what is really important, I mean I work
12 closely with North Central Bronx and the… and the
13 whole community over there, there are real successes
14 in what, what's said by Gray about getting out to the
15 community and letting them know what type of services
16 they have and increasing that ability to do that and
17 getting support for it. The question is how does that
18 translate to the other facilities, how does
19 leadership in those facilities talk to the other
20 facilities and tell them these are the successes and
21 these are the challenges, that needs to be more
22 uniform or figure out a better way to do it and I
23 think it includes community based organizations as
24 well in that kind of process.
25

CHAIRPERSON RIVERA: Well that's… thank you, we are… I am still hoping to, to have hearings in some of the facilities specifically I think on issues that are particularly important in those areas whether it's the neighborhood or whether it's the facility… the facility something that they do really well to give H and H an opportunity to, you know compliment themselves, we'll ask them some questions but also to give them the credit that they deserve. So, I… and I want to thank you all for your testimony today and for all the work that you do.

ANNE BOVE: Thank you…

ANTHONY FELICIANO: Thank you…

HEIDI SIEGFRIED: Thank you for your service.

CHAIRPERSON RIVERA: I don't see any more members of the public that wish to testify and with that I adjourn this hearing, thank you.

[gavel]

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 March 29, 2019