CITY COUNCIL
CITY OF NEW YORK

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TRANSCRIPT OF THE MINUTES

Of the

COMMITTEE ON HOSPITALS

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June 24, 2019
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HELD AT: 250 Broadway – Committee Room
16th Fl.

B E F O R E: CARLINA RIVERA
Chairperson

COUNCIL MEMBERS: Diana Ayala
Mathieu Eugene
Mark Levine
Alan N. Maisel
Francisco P. Moya
Antonio Reynoso

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

Dr. Mitchell Katz, President and Chief Executive officer, New York City Health and Hospitals

Natalia Cineas, Doctor of Nursing New York City Health and Hospitals

Ann Bolle, Retired from Bellevue Hospital on Board of Directors of NYSNA and Board of Directors from CPHS

Judith Kruchten President of the Health and Hospitals Executive Council

Judy Sheridan, President of the New York State Nurse Association

Patricia James, Registered Nurse, Health and Hospitals Kings Hospital, Vice President of the Executive Council of Health and Hospitals and Mayoral, Vice President of the Local Bargaining Unit

Pat Kane, Treasurer, New York State Nurses Association

Karines Reyes, Registered Nurse and Assembly Member, 87th District, Bronx

Ari Boma, Registered Nurse, Department of Psychiatry, Interfaith Medical Center, Brooklyn

Julissa Saud, Adult Geriatric Nurse Practitioner

NYC Health and Hospitals, formerly Pediatric Department Specifically Ambulatory Care, Elmhurst Hospital

Olivia McMyers, Registered Professional Nurse, Accountable Care Manger, Health and Hospitals

Dr. Carolyn Esposito, Registered Nurse, Former Defense Malpractice Attorney, and Educator Director of Nursing Education and Nursing Research, New York State Nurse's Association

Lorraine Ryan, Senior Vice President, Greater New York Hospital Association

Migna Pavaris, Director of Business and Strategic Planning, Arch Care

Scott Amrhein, Continuing Care Leadership Coalition, CCLC

Mahfurur Rahman, Executive Vice Secretary, Community Board 11

Mark Hannah, Director of Metro New York Healthcare for All

Mario C. Henry, Senior citizen, and member of New York State Senior Action Council

Jill Furillo, Executive Director, New York State Nurses Association, Appearing for Greater New York Hospital Association

[sound check] [pause]

CHAIRPERSON RIVERA: Great. [coughs] Good afternoon everyone. Thank you for attending today's hearing. I am Council Member Carlina Rivera, Chair of the Committee on Hospitals, and first I want to acknowledge my colleague and favorite—I mean fellow member of the Committee Diana Ayala. Today we will address Safe Staffing practices in hospitals and hear resolution number 396 sponsored by Council Member Cabrera calling on the New York State Legislature to pass and the Governor to sign The Safe Staff—Safe Staffing for Quality Care Act, and it might happen again today, though. In addition, we will hear Introduction Nos. 1351 and 1352 and Resolution No. 723 sponsored by Council Member Gjonaj regarding emergency room wait times, and a campaign to educate residents about the services offered at different emergency care facilities. Representatives from Health and Hospitals and New York State Nurses Association, NYNSA, and members of the public will provide testimony today. Although our city hospitals are consistently recognized—recognized as some of the highest quality establishments in the nation, there are serious concerns that nurses and other direct

care staff are tasked with excessive workloads. Multiple studies have found the excessive workloads cannot only increases of burnout for nurses, but also increase adverse patient outcomes. Nurses in New York are not alone. Nurses across the country are advocating to implement states passing standards, and California and Massachusetts have both implement laws to require specific nurse to patient ratios. New York State has not implemented any strict nurse to patient or direct care worker to patient ratio requirement. State regulations currently require hospitals to have a director of nursing services who is responsible for and I quote, "Developing a plan to be approved by the Hospital for determining the types and numbers of nursing personnel and staff necessary to provide nursing care for all areas of the hospital. While there are members of the healthcare system who believe it is a best practice to have hospitals inside, the best ratios for their individual systems, a discussion around standardization seems necessary. According to some reports, there are nurse in New York City who are treating up to 15 patients at a time. Regardless of where one's perspective lies, this is a dangerous

situation, which must be addressed. I look forward to discussing different potential ratios and learning more about how staffing requirements are developed. Collectively researchers have been unable to decisively conclude what the most optimal nurse-to-patient ratios are, and individuals organizations and other state governments have implemented their own ideal minimums. For example, NYSNA nurse-to-patient ratios range from one-to-one in the Trauma Emergency Unit to one-to-six in the well baby nursery. During today's hearing I hope to dig into best practices as well as examine all the potential next steps available to our healthcare providers. As a committee and as a Council we must prioritize the health of all New Yorkers including patients, nurses and direct care workers. It is unacceptable to have nurses and direct care workers so overburdened with work that they feel it is a danger to themselves and those that they dedicate their lives to serving. The attainment of high quality care for the New Yorkers and the protection of the employers who make that possible is utmost importance to me, and I look forward to hearing testimony regarding this important issue. I want to recognize my colleague Council

Member Mathieu Eugene, and I also want to read— Oh, and Reynoso. Hi. I also want to read something really briefly from Council Member Cabrera. He asked me to read his opening statement on Reso 396, which is the Safe Staffing for Quality Care. He says, Good afternoon to everyone. Reso 396 calls on the state to pass the Safe Staffing for Quality Care Act to ensure that acute care facilities and nursing homes use appropriate staffing for nurses and unlicensed direct care staff. HHS data shows that inadequate nursing staff levels can lead to poor patient outcomes. Studies indicate that higher nursing workloads are associated with increased medication errors, rates of infection and mortality. Reducing nursing workloads and adopting minimum staffing requirement lead to better patient care, better outcomes and improve quality of life for nurses based on better work conditions. If enacted into law, Safe Staffing for Quality Care Act would enable RNs to refuse work assignments if staffing is inadequate. Ensuring adequate nursing coverage for all patients and safe and reasonable working conditions for nurses are important public health goals. Thank you for your consideration of this legislation. So with

that, I would love to call up Dr. Mitchell Katz from Health and Hospitals and—and [applause] Natalia Cineas. Did I say that correctly in Italian? Okay. You have some fans here on staff. I'm just going to have you sworn in. [background comments/pause] Is there anyone from DOHMH that wants to say anything? I mean that wants—that can be on the panel in order to answer question? We can swear you in. [pause]

LEGAL COUNSEL: 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?

PANEL MEMBERS: [off mic] I do.

LEGAL COUNSEL: Thank you.

MITCHELL KATZ: [off mic] Good afternoon, Chairperson Rivera and—and members of the committee. [pause] [on mic] Thank you. I'm the President and CEO of the New York City Health and Hospitals. I'm delighted to be here. I want to thank the chair and the other committee members for having this hear, and for bringing to light the importance of nurses throughout our hospitals. I'm also very happy to be joined by Natalia Cineas, who's the Doctor of Nursing, and a respected leader and care provider,

and like our chair was born in the New York City Hospital. In the case of our Chair it was Bellevue and in the case of our new nurse leader it was Kings County. At Health and Hospitals nurses are the heart of our mission to deliver high quality compassionate care for all New Yorkers from our emergency departments to our skilled nursing facilities to the Neonatal ICU, nurses are essential caregivers. They not only offer top quality care, but they help patients to navigate a complex health system, which is particularly important for low-income people who have fewer other supports, and who have greater social needs. I've learned a lot in my first year and a half back in New York from our nurses. I've learned that it took far too long to recruit nurses, and that it used to be at Health and Hospitals their recruitments did not even begin until a nurse actually left from a positing, which meant—guaranteed that we would be short staffing a nurse would have to leave before we would even start the possibility of recruiting. That has now been changed. As soon as we know that somebody is leaving, we immediately open the position, and we actually for the first time now have nurses in training who are set for positions

that have not yet vacated, but we know that there's always going to be a certain amount of turnover, and so we want to make it easier for to—to always be fulling staffed. We do an amazing job training with new nurses and we have incredibly dedicated career nurses, but I know that the major problem for us to work collaboratively with NYSNA on is that we often lose early career nurses to private health systems. The basic issue is that we hire nurses out of school. We give them the best training they could possibly get at places like Bellevue or Jacobi or Harlem, and then after two years, they are incredibly experienced, capable nurses who have worked under the most difficult conditions, and so they're incredibly sought after by other health systems, which pay more, and I'd says that's not a very good business model because it's very expensive to train a nurse. Right, a nurse out of school really needs six months to be at the level that he or she can perform as a full and capable nurse, and so by not adjusting our salaries appropriately so that nurses by year 3 to 5 are getting paid appropriate wages. All that's happening is we are—we're serving as a very effective training ground, and I'm sure the other hospitals greatly

appreciate us, but it's not from my point of view a very good business model. We have taken a number of steps to deal with our challenges. I'm very pleased that even though the organization that I inherited had a $1.8 billion deficit. After hearing directly from nurses, and this occurred at our public hearing, when they got up, they were the ones who said, you know, Dr. Katz, you have to do something about our staffing. We are way too low. We made a commitment despite the budget crisis and the hiring freeze to hire net 340 new nurses. So, that's taking into account retirements, leaves, other places people went. We filled—we backfilled all of those, and then we hired 340 nurses. We also previously had no standard staffing plans. So, all nurse units were set at whatever they historically were or however many nurses they had. Dr. Cineas' predecessor, Dr. Mendez did the first nurse staffing plans, which Dr. Cineas is maintaining so that now we have for the first time appropriate staffing levels at our different units. We've reduced paperwork so that we can hire nurses faster, and we've launched a recruiting campaign, which as far as I know is the first recent recruiting campaign that Health and

Hospitals housed it inappropriately as we did with our doctor campaign. It focuses on mission. We want people to come to us for a mission. That is the most important reason to work at Health and Hospitals because you get to take care of people who otherwise would not get cared for. Our contract negotiations began with NYSNA earlier this month. We have a great relationship with them, and we're looking forward to working with them on what we see as a common purpose. We don't see ourselves as having a different agenda than NYSNA. We see ourselves as having the same agenda as NYSNA, which is to make sure that we continue to recruit great nurses, that we have Safe Staffing, that our nurses want to stay with us. We feel if you stay with us two or three years you will so fall in love with Health and Hospitals that it will be impossible for you to work anywhere else. We need to work with NYSNA around specialty nursing care. Although without question nurses across our system do amazing work, nurses in specialty areas in other hospitals do earn higher salaries. So, nurses in the private sector who work in the ED, in the ICU, in the MICU have higher salaries, and if we're going to continue to be able to retain the best nurses, we

need to be able to pay rates that are at least comparable, and it's the same as with physicians. I don't need the highest salaries across the city. I need salaries that when combined with our mission keep the best nurses. I know related to nurse staffing the members are concerned about wait times in the Emergency Department, and that is a very real concern. It is I'd say a complicated issue. This is not a New York specific issue. Wait times and crowding in emergency departments is occurring across the U.S. There are more emergency visits in this past year in the U.S. than in any other year previously, and it keeps growing. I do think it's important that people understand that emergency departments are about triage. So, no matter how long the average wait is, if you come to our emergency department or any credible emergency department with substernal chest pain or trauma, you're going to go right in. In fact, all of emergency rooms are based on a 1 to 5 triage scale. This is across the nation. 1 and 2 means you're going directly in. Three are people who may be seriously sick or my be able to be discharged, and 4 and 5 are people who have problems that could be seen in a—in a primary care setting or

they come into an emergency department. So really what wait times or cause is very long waits for people who are at levels 3, 4 and 5 especially if there are a lot of 1s and 2s coming in, and it-it also causes frustration because people are like, Well, I've been waiting and that person just came right in, but that person came right in because they turned out to have substernal chest pain, or sings of a stroke, and so the—the more people who are critically ill the longer the other people are going to wind up waiting. That's not meant as an excuse, but it's meant at least to reassure people that across the nation emergency rooms are set for triage, but we do need to wait—we need to shorten waits for people who are coming for—for example problems in the 3 area can be a serious headache. It can be serious abdominal pain. So, these—these are not trivial issues. This is not, you know, a runny nose that we're talking about, and having to wait hours and hours while you have abdominal pain is a problem. Nurse staffing is one factor in wait times, but it's certainly not the only factor, and if we're going to improve the situation, we're going to have to work on all of the different issues that affect emergency

rooms waits. We have 9,600 full and part-time nurses at Health and Hospitals. My commitment to Safe Staffing is absolute. My elderly parents, my husband I always seek care at Health and Hospitals, and my daughter will as well when she arrives in July. I certainly wouldn't have my family be seen in a place that I didn't believe was safe, and I will not rate facilities that are not safe. I want to continue to hear from nurses about how we improve our care. I'm very happy with the relationship that we have with NYSNA. I see them as our partners in making things better, and I—I look forward to hearing more guidance and—and leadership suggestions from the City Council, and working with all of you, and the great nurses in my system. Thank you.

CHAIRPERSON RIVERA: Is anyone else going to testify? Okay.

MITCHELL KATZ: I think Dr. Cineas is. If you have questions—

CHAIRPERSON RIVERA: Right, we will.

MITCHELL KATZ: --we'll answer many of the more technical aspects of our nursing.

CHAIRPERSON RIVERA: Great, and Dr. Katz, I—I agree. I want to—I think we've worked well

together. We want to be very supportive. I try to show up to all the things that you're doing in the Health and Hospitals system, whether it's a pride censor or whether it's discussing how public charge could affect the very culture and nature of how people come into the hospital, and I am interested, though, to know specifically your thoughts, H&H's thoughts and the city's feelings on the legislation before you today. You mentioned Safe Staffing and as being important, and you mentioned emergency department wait times, but you didn't say whether or not you I guess approve or—unless it's somewhere in here, whether you support or oppose the legislation.

MITCHELL KATZ: Right. So, personally, I support the legislation. I support Safe Staffing. The—what the exact legislation says and how it affects our negotiations with NYSNA is from my point of view to comp, right. The legislation certainly has implications, financial implications for the city, and it affects our contracts with NYSNA.

CHAIRPERSON RIVERA: Uh-hm.

MITCHELL KATZ: So, I see it as something we would do together. I see the first year and a half as going from a place where we didn't even have

staffing ratios of any kind, and we didn't have—and we clearly had, you know, ratios that weren't anywhere near what the legislation currently requests, but I—I think Safe Staffing is clearly the right thing to do.

CHAIRPERSON RIVERA: And—and so, let's talk a little bit about the—the legislation before us, and a couple things that you mentioned. Do you want to want to say something before you go? Okay. Before—before I get into questions, I want to just recognize Council Member Mathieu Eugene, our resident physician in the Council, and I know you wanted to make a few remarks as a Council Member.

COUNCIL MEMBER EUGENE: Yes. Thank you very much. I'm going to be very brief. Thank you, Madam Chair. Commissioner, I want to thank you for the effort that you are doing to correct this situation. This is one of the two, and I think that when we talk about Safe Staffing for nurses, we shouldn't have to discuss the debate to find them and finding for so long. (sic) So long since—but my question, and you have to translate now because unfortunately I have a—I got a—I got a dental appointment. I go to go, but I'm asking if at this

time as we speak did we fill the gap? Are we in the situation to say yes we will—we—we reached the ratio, and it's the same ratio for nurses and patients in order to make the life of our patients, in order to—to do justice to the nurses. You're about, you know, being fair to the nurses, being fair to the—to the patient. Talk about the—the safety of the patients. We are all human beings. It doesn't matter our intention and how educated you are and in serving their bodies so recent. (sic) You have a staff, you have a staff. We know that brilliant doctors, cardiologists they have a heart attack, you know, they become sick also because it is not easy. Being a doctor, being a nurse it is not easy. This is a very heavy job. So, I'm –I think that you mentioned that something about that you mentioned education for the city but half of the people don't have the price. When you're talking about half of the people in New York City we are obligated. We are elected officials. You are from an agency to do everything that we can do to ensure that the patient, the New Yorker the hard working people when they are in the hospital, they are in the position to be receive it proper. The state of the art, you know, medical

care, but the staff that is providing the services for them are in the position also to continue to deliver the best services possible. So if we don't have—if we don't do our facility to hire the number of nurses, our nurses to do the job, I don't think that we are giving justice to the patient. One other thing that you mentioned that, and I have been seeing that we—we place the nurses when there is an, in fact, a position vacant, but we've got to be prepared before that. Some of the time the nurses are not trained properly. They—they have to spend some time to be trained to respond to that and to somebody. (sic) We need qualified and trained nurses even we don't have to wait when a nurse, you know, is forced to leave or got less of the situation to increase the nurse, but we got to make sure we got the necessary number of nurses to do the job, and again I applaud what you are doing, but I hope that we will have next time to do it on the steps of City Hall. You know, we won't have to go to, you know, in the street to argue and to protests to find, you know, all the nurses. I think it is our moral obligation to do as the chair said we City Council members where we can work together with you, with the Administration to

ensure that we correct that. We have to do it. It is an obligation. Thank you very much.

MITCHELL KATZ: Thank you, Council Member.

COUNCIL MEMBER EUGENE: And to the wonderful nurses who are there day and night, I know that—I said the before we said city never sleep. I know you never sleep. You don't sleep also. You know, you--you know. You don't sleep. When I say you don't sleep because the nurses they are there 24/7. So, of course, they got to sleep, but 24/7 we have the nurses taking care of the patient. Thank you for what you are doing for our constituents and thank you Chair—thank you Madam Chair. Thank you.

CHAIRPERSON RIVERA: Thank you. I guess there a difference in getting sleep and running on adrenaline, right, and wanting to make sure that you are of sound mind and body. I know it's physically, emotionally, mentally, spiritually draining, and we want to make sure that we are creating and improving a system that I think is already—it's not just the largest one in the—in the country, but it world class in many, many ways, and people come from all over, and receive amazing quality healthcare. For Dr.

Katz, specifically you were the Director of the Los Angeles County Health Agency, and a practicing physician in the State of California. I know you're back in New York, and-and we're glad that you're here. They've implemented regulated nurse to patient ratios, and what was your experience implementing these ratios?

MITCHELL KATZ: It was in California there was a lot of protest before the ratios got passed just as it's been in New York. My experience of doing it was very positive, and in there you have to be able to recruit the nurses, and I—I think that's one of the reasons why I reflect that no matter what, solving this problem requires a close collaboration between us, NYSNA and the City. At this moment, my biggest problem is recruiting and keeping nurses. It isn't actually the number, right? I mean if you put before me 30 great nurses, I'm—I'll hire them, right. So, right at the moment in places where I have a ratio on paper, I can't meet the ratio because I can't hire 30 great nurses. So, that's part of why—and-and that's especially true again in the—in the areas that requires specialized skills. OR's NICUs, emergency rooms, which is some of the

places we run the lowest. So, it—it—to fix this we have to fix all of the different parts, but—but overall I would say the experience of California proved that no it dose no bankrupt all the hospitals and they don't all close. I don't-I'm not aware that there were any hospital closures in California over nurse ratios, and that it is attainable. You do have to be able to recruit the nurses, right no matter what your quote/unquote "mandatory staffing" is, is you don't have the nurses, you can't meet the ratio.

CHAIRPERSON RIVERA: And do you think it improve the overall experience?

MITCHELL KATZ: I think there's—there's very strong data that the number that the more nurses per group of patients the better the outcomes. I don't think anybody disputes that.

CHAIRPERSON RIVERA: I appreciate what you said about bankrupting hospitals, and that kind of not being a factor considering. So, you said that you've hired 340 new nurses, and the breakdown, or what you gave us was 9,600 full and part-time nurses. Does the 9,600 include the 340?

MITCHELL KATZ: Yes.

CHAIRPERSON RIVERA: And do you know that's the breakdown between full and part-time?

MITCHELL KATZ: I don't. Do you?

NELSON CHAN: I don't in the 9,000.

MITCHELL KATZ: But we'd—we'd be happy to--

CHAIRPERSON RIVERA: [interposing] Okay.

MITCHELL KATZ: --provide that.

CHAIRPERSON RIVERA: How are—I know you have nurses for NYC, and that's your recruiting effort. How are the efforts going?

NELSON CHAN: It's going really well. Within the first week I received a email from HR. We'—we set up a call, and we have 80 resumes. So, it's really working. We focused on Correctional Health, Emergency Department, Ambulatory care, and the response has been overwhelmingly positive.

CHAIRPERSON RIVERA: And when you mention those that are coming in to see—to receive care some that you mentioned the 1 to 5 Scale—1 to 2 being the most dire when someone absolutely needs to be seen. How are you--and this goes to some of the legislation before us today—how—how are campaigns out there educating people as to when to know when a runny nose

or a 4 or a 5 is something that you could actually go see your PC—your primary care physician for, even with the new urgent care that you have that you're rolling out of the Health—the Health and Hospitals' facilities?

MITCHELL KATZ: Well, I think that's really and insightful question because it's at all levels. So, for example just to start at the opposite level that you did, there is now really compelling medical research that you can do something about stroke. So, when I trained, you know, if someone had a stroke they might not have gone to the emergency room. There's nothing to do. It's a very serious thing, but nothing to do, right. You just wait to see what the level of deficit is, and do rehabilitation. Not true any more. Now, if somebody is experiencing the signs of stroke, right, which are predominately one-sided weakness or change in sensation or inability to speak, you want them to go immediately to an emergency room. You don't want them to wait, and so there are campaigns not by us, but nationally on stroke. So what you want are campaigns that are around the one and two issues especially stroke and chest pain. If someone has a

fun got, they know they have to go to the emergency department, right? I mean people, a lot of people associate okay I got to go. What—what you want is that people who have the kinds of symptoms, oh, my left arm is a little achy and my—my fingers feel kind of numb. I'll just wait and see if that goes away. Right. No, you guys are the emergency room. The same with people who have, you know, strokes= symptoms. On the other hand, for the ones you raised 4 and 5, where we really want our message to be, you know, if—if you are having a cough, you know, you have an ear ache, your ankle or knee is bothering you, you should see your primary care doctor where you'll have a better experience. You'll build continuity. So, we've—we've been focused primarily in Health and Hospitals on trying to teach the people in the—the 4 and 5 areas to go. We've had a very positive experience with Express Care, and I appreciate that this Council has been very supportive of it. We have it running at Lincoln Hospital and at Elmhurst, and it's making a huge difference, and the basic idea of Express Care was let's help people who have always gone to the emergency room to know that they can get care in a primary care setting, but they

still if they arrive in the emergency room we can get them to a primary care setting. So, instead of trying to message something very complicated, when they arrive at the ED, we say you could—you're welcome to stay at the ED, but if you do, though, just around the corner—not around the street corner, but just around the corridor corner you can be seen in Express Care, and you'll be seen right away, and so now 4s and 5s of those two hospitals are being seen often in and out within an hour's time. We're going to open in Jacobi in a few more months. We appreciate the support of our Council Member from Jacobi. We're going to create an urgent care at Googan Europe (sic), which the Chair has raised. We—we already have. It means unfortunately in terms of delay the ideal space that you and others have pointed out is a non-patient care space. So, it requires a CON with the state, but it—I mean it just means three or four months more we have to apply to change a non-patient care space into a patient care space.

CHAIRPERSON RIVERA: And we—we could talk about the CON process all day because that's another issue.

MITCHELL KATZ: Right.

CHAIRPERSON RIVERA: I know it's a state issue, and I'd love to kind of pick your brain about how to reform it. So, I—so you mentioned the emergency room, and-and trying to at least direct people to what other services could—could be more appropriate, and that's great. I—I think the—the conversations that have been alarming that we've had with the nurses are it's—it's—even though we're trying to maybe redirect them to have a primary care physician or to go to Express Care, they are still being forced to make some decisions that no medical professional or person in service should have to make between someone who has an asthma attack or someone with chest pains, and some of these stories are absolutely heartbreaking, but these women most women, of course, that it-it is diverse, but they are completely dedicated and—and you do have some incredible nurses within you system.

MITCHELL KATZ: Right.

CHAIRPERSON RIVERA: So, so since it's clear that we need more nurses, we need nurses from all different backgrounds and—and-and really wanting to make sure that—that we're keeping them happy in

the best way we can knowing they're committed to the mission. How did recruiting in Los Angeles compare to here? Is it more difficult?

MITCHELL KATZ: The big difference that I had in Los Angeles that helped me is I had premiums for the specialty type services like ICU, Neonatal, OR. I had differentials for hard to recruit areas like in Los Angeles that was Antelope Valley, but there are places here where it's harder to recruit even though it's not in Antelope Valley. So, that made a difference and I had better steps for nurses especially again the critical area, and again, we want to work with NYSNA and I appreciate their input, but from the data I've seen the most critical area is about Year 2 to 5 or 6 where we don't step up the pay enough. So, we—when the city's Office of Labor Relations looks at my nurses, they way well you can hire nurses, and it's true. I can hire nurses out of school, and the reason I can hire nurses out of school is because we have hospitals that don't hire nurses out of school, right. So, so, yes I can hire nurses out of school. That—then I have to spend six months at the city's expense training them. Then at year 2, I don't have the kind of staff to keep them.

So, you have some amazing career nurses who are so committed to our mission that they're willing to earn $20,00 or $25,000 with us, and that's—I'm lucky to have such, but other people, you know, people have expensive. New York City is an expensive place to live. They go another institution. Once you get to year 5, 6 or 7 you're usually okay because obviously they've made their major commitment. I'm not saying—I mean people always move and change, but it's those years where in L.A. I had more of the steps that would keep somebody in going. Also, the city's pension helps once you get to 6 of 7 but, you know, you can't--at year 2, you can't tell a nurse well if you work 30 years you're going to have a great, you know, pension, right, and the nurse is going to say, well right now I'm worried about paying for my kids' school—shoes, right. Don't tell me, but once you get to year 7 or 8 right, and there's a pension at 10, right years, right and—and it helps. So—so I need those things. That's what I had in L.A. that I don't have here.

CHAIRPERSON RIVERA: Okay. I have a couple colleagues that I want to make sure they get to ask questions because it is a very busy day here

at the Council, and I want to start with Council Member Ayala.

COUNCIL MEMBER AYALA: Thank you, Madam Chair. I just have two questions. The first question is in regards to Intro I think 13—actually Intro 1351. So, in your opinion has the redirecting of patients to urgent care translated in a reduction in the number of patients being seen in the ER?

MITCHELL KATZ: We have a small reduction on patients being seen in the ER. We have a major—the major improvement, though, is the—it's how long people from the 4 to 5 group are waiting. So, if they would have—in other words, there is some replacement. You have a bunch of people who were once in ED. They're now going to Express Care, but we've had some more people now coming to the ED. So, it hasn't so much decreased the ED wait time, but you have a large group of people who are being seen in and out within an hour, and being connected to primary care. So, maybe over time as more and more people get used to the primary care model, it will increase ED-decrease ED wait times.

COUNCIL MEMBER AYALA: So—so, you're opinion on the creation on—of some sort of outreach

campaign do you think that it would—would it be helpful?

MITCHELL KATZ: I think as—as long as it's in the ways we were talking about directed on who really needs to go to the ED, right for stroke, the heart attack, and who really needs to go to primary care. So, it can't be we want everybody to go to primary care because we don't want people with substernal chest pain going to primary care, and it can't be—we want everybody to go to go to the ED if they have a need because we'll swamp and they'll wind up with long wait times. So, I think that the campaign has to be sophisticated to be about illness, and people get it. I think that the—the Stroke Association, which is a national association has been very targeted, and I think successful at teaching people the signs of stroke, and to me, you know, that's what—that's the level of campaign. You want the people to get the right care in the right place.

COUNCIL MEMBER AYALA: Great. Thank you. It's—I'm not sure that this is a question for you, but in regards to Resolution 396, Resolution 396 calls on the State Legislature to pass the Safe Staffing for Quality Care Act to ensure that acute

care facilities and nursing homes meet the appropriate ratios. Do you know what the current ratios are?

MITCHELL KATZ: Yeah, they—so, the legislation calls for a 1 to 4 in medical surgical wards, which is the bulk of the hospital, and that's the same as California. Just to give you a sense of the difference in what we're able aiming for is 1 to 6. So, that's what our staffing is currently based on, and that's because of my observation that in some places we weren't anywhere near 1 to 6. While again, if you go back to when I arrived there was no plan. So, we were—whatever we were at, and in many cases, and the Chair referred, there were rations that were completely unacceptable to me.

COUNCIL MEMBER AYALA: That is for nursing homes and acute care facilities.

MITCHELL KATZ: 1 to 6 is any medical surgical ward. I'm not sure in skilled nursing. Is it—well, it's by not 1 to 6. It was—it's a little different.

NELSON CHAN: [interposing] No, it's not 1 to 6. It's something different, but that's not outlined on our Staffing Plan at the moment. We're

working through that, but that's for all the acute inpatients. It's 1 to 6.

MITCHELL KATZ: But ICU would be—is not 1 to 6. ICU is 1 to 2.

COUNCIL MEMBER AYALA: Correct, but the level of care the reason I asked is because the resolution specifically speaks to acute care facilities, and nursing homes, and I'm trying to make the distinction between the staffing needs at a clinical hospital as opposed to a nursing home.

MITCHELL KATZ: Ah, so--

COUNCIL MEMBER AYALA: [interposing] Are they the same? Are they comparable or--?

MITCHELL KATZ: No, they—they're not—they're not the same. I mean people in nursing homes are obviously by—by definition don't have acute illness, but they need a lot of care, generally more of the care is at the level of the personal care attendants because if they were acutely ill they would be in the hospital, but you still need registered nurses. Only registered nurses can do nurse assessments. So, we need, registered nurses because someone in a skilled nursing facility might suddenly develop a cough or shortness of breath.

There has to be a nurse to assess them, and nurses are needed for all of the prescriptions for medications, but that we—we don't yet. Again, a year and a half ago we had no established work plan for any of our facilities. Now we have it for the acute care. We're working on it for nursing homes.

COUNCIL MEMBER AYALA: Uh-hm. Okay. Thank you.

CHAIRPERSON RIVERA: Thank you. Council Member Levine.

COUNCIL MEMBER LEVINE: Thank you so much, Madam Chair, and it's—it's great to see you, Dr. Katz and your team, and—and I appreciate not just your work in general, but what you said today about the importance of nursing, one of the toughest jobs in our society, one of the most important, and as you thankfully have acknowledged this is about patient outcomes. Data has shown for—for years maybe even decades that the level of nursing staffing directly impacts health outcomes for the patients in the care and—and you've acknowledged that and we appreciate that. I will say that I think your frustration about retention of nurses is directly connected to staffing ratios because burnout is—is an unavoidable result

when nurses have unrealistic workloads. It impacts patients first and foremost, but it also impacts nurses who even under the best of circumstances front line nursing is so stressful and so difficult, but when you have 5, 10, 15 patients, and we do hear reports of—of levels that high, my goodness. I can only imagine the impact on those professionals, and sure you're going to lose patients who can go to private hospitals, voluntary hospital where the ratios are lower. Probably not low enough there either but, my sense is that probably lower than they are in the public hospitals. You have identified 4 to 1 a s the standard set in California, and 6 to 1 as your current goal, but I gather that you're not always able to meet that goal. Is that right?

MITCHELL KATZ: That's correct.

COUNCIL MEMBER LEVINE: So, can you speak about how frequently you are at ratios higher than 6 to 1, and what you have seen as the highest ratios that you've had to endure?

MITCHELL KATZ: Sure. So, the—the way that it currently is, we are—we have a plan for every ward to hit 6 to 1. So, but—if we can't recruit the nurses, we're not at 6 go 1, and then what we're at

is some combination of whatever loss we have at—at recruiting, and then also 6 to 1 if there are a variety of people who call out sick, which occurs as you correctly point out because people are burned out. Right, so, and -and it's—it's about cycles. So, if—if a number of nurses go out because they're burnt out, then a nurse coming in knows how hard it's going to be. So, even if you call for, you know, back-up, people don't want to come in because they know that they are potentially, you know, going to be nursing under incredibly difficult conditions. So, I think, you know, on—on wards I've certainly known especially at nights on weekends that it has been at various times at the beginning before we did this, you could—you could easily have had 1 to 9 or 1 to 12. I don't think that—that that's currently today, but again—

NATALIE CINEAS: That's, of course, is correct. We started—I started—I was appointed March 11th, and we started daily staffing calls throughout the entire system for acute inpatient and for the most part, we do hit the 1 to 6. As he mentioned, it's usually night shift sick calls, but that's why we started the New York--the Nurses for New York City Campaign just to really, you know, boost the number

of nurses with partnership with NYSA, of course because we're working as fast as we can.

COUNCIL MEMBER LEVINE: And in addition—in addition to difficult commissions because of staffing ratios, another factor affecting recruitment and retention are salaries. I know this is not a collective bargaining negotiation. This is a City Council hearing, but the truth is that all the nurses that work for Health and Hospitals know that they could get more money in other environments. Now, they are dedicated. I've met so many of them, and they believe profoundly in your mission, and in the mission of supporting the neediest New Yorkers and—and-and I and I'm sure you are so grateful that they've chosen--

MITCHELL KATZ: Absolutely.

COUNCIL MEMBER LEVINE:--to—to—to pursue a career in our public hospitals, but you can't avoid the fact that they all know that they can go for—they can get a higher salary elsewhere, and so that's critical to the recruitment problem. It's—it's what you pay in a marketplace, and it's the kind of conditions you can offer through ratios. So, I really urge you to do what you need to, to attract and

recruit the great talent that we need, and to do everything you can ultimately for the sake of patients, and we keep talking about nurses because they matter so much, but nurses will be the first to acknowledge that issues about patients and giving the best care that we can to them and we know that having well supported, well compensate and—and most importantly having the right ratio for our nurses is the best for everybody in the system.

MITCHELL KATZ: Thank you. I—I really appreciate the City Council's support. It means a lot. This is a—an example where this is not like hiring in other city positions. Again, you can't—a standard way, and this is true in L.A. and San Francisco, typically in City government you say well, can you hire? Okay, I can hire. I can hire brand new nurses out of school, right. Part of it is teaching the-the system. Well, but—but that I need to keep nurses, right. The—the question of whether I can hire new nurses to fill vacancies is not the whole issue, and a nurse is not a nurse is not a nurse. Right, if I don't have 01 nurses, I can't do surgery, right--

COUNCIL MEMBER LEVINE: Right.

MITCHELL KATZ: --and I could have enough nurses at medical surgery and still have a serious problem that impedes my ability to deliver care, and—and so I need help with working with the city system to understand the complexity of nurse staffing and I think NYSNA has a lot of expertise and Dr. Cineas really knows the field and I think together with the help of the Mayor and the City Council this is a solvable problem.

COUNCIL MEMBER LEVINE: Yes. Okay, thank you again Dr. Katz and to your team, and thank you, Madam Chair.

CHAIRPERSON RIVERA: Sure, and-and mentioning, you know, the patients, community members are—are really concerned about the consolidation of the hospitals across the city. This has been ongoing. There are local campaigns to try to save hospitals. Many elected officials have run on this very platform. How many emergency departments were in the city five years ago compared to ten years ago, and how does that compare to today?

MITCHELL KATZ: I'm going to turn to my colleagues in Public Health.

So.

MITCHELL KATZ: Introduce yourself.

RICHARD SU: Richard Su (sic) New York City Health Department. Currently there are 53 emergency departments in—in New York City. We are—I—I don't have the number of emergency departments from 5 or 10 years, but we could get back to you.

CHAIRPERSON RIVERA: I'm going to turn to Council Member Gjonaj in a second. He has questions about the emergency department. I—I just want to know have there been increased wait times or other negative effects on emergency departments as a result of the consolidation from what you've—from what you've seen in the data you do have.

RICHARD SU: So the Health Department does not have data on that topic so we're not aware of that. I would defer to Health and Hospitals on any question about the trends within the emergency department in H&H.

MITCHELL KATZ: But I would just say nationally wait times are up. I mean not just in New York. It's a national—it's been a national issues.

CHAIRPERSON RIVERA: Thank you. Council Member Gjonaj.

COUNCIL MEMBER GJONAJ: Thank you, Chair. Dr. Katz, first of all good to see you.

MITCHELL KATZ: Good to see you, and thank you sir.

COUNCIL MEMBER GJONAJ: I think the world of you--

MITCHELL KATZ: Thank you.

COUNCIL MEMBER GJONAJ: --and the—the work that you've taken on, you know, to really turn HHC into the healthcare provider for New Yorkers is a—nothing short of an incredible undertaking and I'm looking forward to being a partner with you as we meet the hurdles ahead of us.

MITCHELL KATZ: Thank you, sir. I appreciate that.

COUNCIL MEMBER GJONAJ: For full disclosure my wife is a registered nurse. So nurses are very near and dear to my heart.

MITCHELL KATZ: You married well, sir.

COUNCIL MEMBER GJONAJ: It means that I have been trained and programmed to say that repeatedly, although she's a school nurse, and the work that nurses do is by far nothing short of God's work, and the overwhelming concerns that I hear

repeatedly from my nurses is they get caught up more into the day-to-day of recordings instead of providing the healthcare services that they need. You know, I—I—I just hope the stories are told. Could you imagine this, I have had my nurses actually gave massages to the patients, and it wasn't just basically they have a chart and checking off boxes. There was an interaction there, and it's a very difficult and tedious occupation when you have X number of patients and it's this requirement of having to fill out all these forms, and the interaction the compassion that's needed as well as the safety needs are impossible to meet. So, we have major issues ahead of us, and hopefully we can work on what most of my colleagues also brought up, but safe staffing is a major concern, and ultimately it's in the best interest of the patient. Now, let me being with the real stuff. That was the easy—that was a soft ball. I want to get into the emergency rooms. I've introduced two bills and a resolution. Intro 1351 where it require--the proposed legislation requires New York City Department of Health and Mental Hygiene to conduct an outreach campaign specifically, but not exclusively targeting schools

and senior centers to inform New York City residents about the types of urgent care and emergency care facilities present in the city and the kinds of services they generally provide. Now, we know that there's a problem with our emergency rooms where they're being use for the primary care physician. They're being used for non-emergency issues. So, whether it be a headache or cough or sneeze we're allow our emergency rooms to take the role of primary care physicians, which is creating a longer wait time. Now, certainly while we try to educate the current society on when you use an emergency room, and when you should be going to urgent care or primary care physician. Investing in their future is for them. You have to be proactive about this, and it's why aren't we educating another generation? And that's our children so they know when to go to the emergency room whether it be for stroke, or whether it be for chest pain or shortness of breath or gunshot wounds that you know need immediate attention. We need to start educating, and with educating our children, they do something else. They go back home and they educate grandma and grandpa and mom and dad. Those children are sponges. So, we

change behavior, and we educate using that group as a platform and the seniors obviously for the obvious reasons because they tend to have needs of the healthcare system more than anyone else. Second, Intro 1352 require the Department of Health and Mental Hygiene to study the causes of prolonged wait times in the emergency rooms as well as the effects of such wait time on the patient's health. Now this is extremely concerning to me because we know and emergency room you're being exposed to all sorts of airborne bacteria. Who's coughing, who's sneezing? So you can come in what sickness and leave with something else. Along with that patient is the family member that accompanies the person. So, whether you're taking the children in need of this, obviously, you don't know what time you're going to get our of an emergency room or you have a family member accompany you, you're exposing a healthy person potentially to an environment that isn't so healthy. The effects of being in an emergency room and we know that, you know, enhanced or not, there's always a problem. So, I would hope that this would segue into the third issue, which is a resolution of calling on New York State—State Legislature to pass

and the Governor to sign legislation requiring hospital emergency departments to improve their service to better inform patients of their potential wait time and other care options. I envision some day in the near future where you can pick up a phone and call 311 give a zip code and an address and ask where is the least amount of wait time in an emergency room whether it be private or public. I envision day where a car can pull up and actually see a digital display expected wait time before you park and get out of your car and do the registration, and also inform you that a nearby hospital has a lower wait time. I envision the day where ambulances that are summonsed to these 911 calls can make a determination especially in some areas of code purple where we know we have an inundated emergency room. We know they have—there's no available beds in the hospital that they could assess the medical needs and possibly take them to an urgent care facility or an express care facility as you mentioned. These are all within our reach, but worst part of all of this is according to some of the recent publications, in New York State the New York City hospitals have some of the worst wait times in the emergency rooms in the

entire state, have some of the worst wait times for available beds, spending days in corridors waiting for a room, and some of the worst wait times to see a physician, all making experience one that prevents people form seeking healthcare, not getting the healthcare, and we have to be proactive and not reactive. Not giving them the encouragement to go to an emergency room if need be or an urgent care for fear of what the outcome may be. New Yorkers deserve more than the current treatment that they get. This is some of the—our role in government, our priority is health and safety. Everything is just secondary, and to our most vulnerable the second. So, I want to hear from you on what you think of these three bills, what we align or describe is something in the near future will help improve the healthcare services in an efficient way and the most effective way, and to make sure that we don't overburden our healthcare systems, our safety nets treating non-emergency issues in and emergency room environment. Thank you.

MITCHELL KATZ: I think you have a very thoughtful critique, and I think you're right on—on all the points. I think these are all problems that together we can solve. They do have multiple parts

to them. A couple of thoughts to amplify the things you said. One of my critiques of the way the primary care is set and the way most private doctors offices are it's Monday through Friday 9:00 to 5:00, and probably not Friday afternoon. Imagine how any of us would feel if the airlines were like that, right. If you wanted to fly somewhere and they said to you, oh, well, you can only fly Monday through Friday 9:00 to 5:00. You'd be well what do you mean? There's no inherent reason why—why outpatient centers can't work in the evenings and the weekends especially in most families where two parents are working right in order to make a living to live in a place like New York. So, I'm pushing hard on the idea that we at Health and Hospitals need to have evening hours, and we need to have weekend hours. The other one that I think can help is that there's new federal legislation that would allow an ambulance to bring someone who called 911 to an alternative destination. So, it used to—well, still today you call 911, the ambulance comes, and you want to go to urgent care. They can't take you and get paid. So, they won't take you, right they=--they're—they're either--

COUNCIL MEMBER GJONAJ: [interposing] And Dr. Katz--

MITCHELL KATZ: Yeah.

COUNCIL MEMBER GJONAJ: --what's the cost of an ambulance ride?

MITCHELL KATZ: Oh, my God. I'd say at least a $1,000.

COUNCIL MEMBER GJONAJ: Could you imagine that we're spend a $1,000 on transportation is really what we're doing.

MITCHELL KATZ: Right, absolutely. It's a huge mistake, right. So, I—but I think, you know, all—you have all the right points. We want to—we want to educate people about who really needs to be in the ED, and who doesn't so that you—you—you have the right. The people getting the right care in the right place. You don't want people sick for reasons that they—of what they're exposed to. There is no reason in this technological world where we can all order dinner and know right on our phones when they're preparing it. I ordered my elderly parents dinner last night. Right, they tell me when it's in the kitchen on my phone, when the person leaves the delivery, and then why for something that's really

pretty trivial I could just wait the 40 minutes. My parents aren't going anywhere, but-but for a life threatening issue we—we can't know that. There's no-there's no technological reason, right. Again, we—we have to as you're doing prioritize what people acknowledge. I think at this point, though, I do want to—to sum up. The first two things are specific to the Department of Health. May we ask—

COMMISSIONER GJONAJ: Absolutely.

MITCHELL KATZ: --them their view?

COUNCIL MEMBER GJONAJ: And I want to thank the Chair for being so patient. I'm a bit long-winded.

RICHARD SU: So, thank you, Council Member for that—for your questions. I just want to note that—so we are—we are at the department, as you know, interested in protecting health of all New Yorkers and we have a variety of campaigns. We are, though not in a position where we have legal jurisdiction over the hospitals in New York City. The state regulates all hospital in New York City.

COMMISSIONER GJONAJ: Repeat that one more time because we're going to dissect that. What—this is about how we improve healthcare and I

understand that New York State dictates most of the policy, but there is certainly something that we can do collectively especially when we're thinking about the-when we—when we understand the actual breaks and what's not working, collectively whether it be patients, hospitals, labor, and government, we should all be sitting together and deciding what to do to improve healthcare more efficiently and more effectively.

RICHARD SU: Absolutely and—and we share—we share your—we share your concerns. I—I just wanted to note that we don't have legal jurisdiction and we do not license and regulate the hospitals. We have a variety to campaigns where we are always seeking to inform New Yorkers about the options including our Get Covered NYC Campaign, which provides free health insurance enrollment and educational materials to both help New Yorkers get health insurance, but also understand their options. Understand that are interested in encouraging the use of primary and preventive care. That's a partnership between Health and Hospitals, the Department of Health and Mental Hygiene, HRA, the Mayor's Public Engagement Unit and

other city organizations and agencies because we want people to know what their options are.

COMMISSIONER GJONAJ: So, what are we going to do to encourage? Because we have to educate and then use some encouragement is a loosely defined word.

RICHARD SU: We share your goals, and so we are looking forward to having future conversations with you about both the intent of these bills, and what we can do together as city agencies and at city government, and—and we're interested in working along with other partners in the community as well.

COMMISSIONER GJONAJ: So, over the summer DOH can be working on a program that would just early educating elementary school children on when they should use an emergency room and when they should seek other healthcare services from primary care to urgent care to having their own primary care physician.

RICHARD SU: So that's something that the Department of Education, and the Office of School Health both in the Health Department and the Department of Education would be something we want an

involvement, and have conversations with them about what we can specifically do in schools.

COMMISSIONER GJONAJ: Great. So, I'm looking forward to working on that over the next three months ahead of the new school so we can actually have a curriculum, a programs in place.

RICHARD SU: We look forward to discussions with you on this.

COUNCIL MEMBER GJONAJ: Thank you.

CHAIRPERSON RIVERA: Okay. A very ambitious summer.

COUNCIL MEMBER GJONAJ: I wanted Commissioner—did anybody answer? Do you want them to get back to you Dr. Katz or--?

MITCHELL KATZ: I—I—I we just want to work with you. I think that this could make a huge a difference for health in New York City and for the running of the hospitals.

COUNCIL MEMBER GJONAJ: And just for the record, I can go online now and I can register in Westchester and my claims with an urgent care online telling me my wait time is five minutes. I'm pre-registered when I get there. So, I don't have to spend more time in an environment that could possibly

have airborne illnesses, and expose me to other ailments that I should be worried about?

MITCHELL KATZ: It proves your point. It's entirely—the technology is not the issue.

COUNCIL MEMBER GJONAJ: Thank you. Thank.

CHAIRPERSON RIVERA: We'll have a hearing on that with the Technology Committee and the new Chair. So, I just want to ask maybe one more question because there are a lot of people here to testify, and I want to make sure that I get to them, but I also know that they were very interested in hearing your testimony, and answers to our questions to further their advocacy and their information. So, the Nurses incredibly important. We talked a lot about that today. We mentioned the patients. I want to ask about the—the team like the team that is in place in our public health system. It's the nurses but it's also the nurse technicians. It's the doctors, and—and it's—it's everyone else, administration, people who are really trying to work together to run these really fairly large facilities some of which as we all know there are 150 languages spoken in—in them. So, what are the current

workloads for direct care staff in New York City? For example the nurse techs?

MITCHELL KATZ: Okay. you know, I don't have the number, but I want to still say have important your point is from a real life issue that happened last night at Harlem Hospital. Dr. Weigh (sp?) who is our Chief of Quality he works in all our Emergency Rooms, and he worked at Harlem last night, and he was talking about one of the challenges he faced as a physician—as emergency rooms physician is that the hospital only had two patient transporters. You say well patient transporters aren't—this is a—this a hearing about nurses, but if the patient has to go to the MRI scanner or the CT scanner, and you don't have any patient transporters, what are you going to do? Well, either a doctor or a nurse has to transport the patient, right. So, I mean at every level as you began the question, it's a team sport, right. If you—say I'm on—on a medical surgical board. If you don't have enough personal care systems then the registered nurses who are incredibly well trained at changing the limit. Well somebody has to change the limit, and you don't want patients in soiled linen, but you don't need to go to school for

multiple years to change linen, right. It's a—it's a wrong responsibility for a registered nurse. So, I mean I—I'm going to turn to Dr. Cineas on—on our goal, but all of our—our staffing plans have to include all of the other people who passed the work of nurses. We're very specific on with our registered jobs, but caring people are going to do whatever patients need, but that doesn't always lead to an efficient operation if you're using registered nurses to transport patients.

NATALIE CINEAS: Yes. So, for ancillary support right now the goal is up to 8 patients each in a med-surg unit and it varies based on the unit. Of course, in critical care they would have less patients, of course.

MITCHELL KATZ: And you mean personal care assistance by a

NATALIE CINEAS: [interposing] Right.

MITCHELL KATZ: --right.

NATALIE CINEAS: Right, by patient care associates.

MITCHELL KATZ: But we also have to, and again this is and remember that at least the organization about 16 months ago all of these things

were historic. If there were four transporters in the hospital on night shift, there were four, right. So, the-and if two call out six, the there are two. The idea is to move the way a modern hospital is run. When you say—you start by how many transporters do I need for this volume of patients in order for the nurses not to have to transport the patients, right, and do, it—it can be the number of radiology techs. Again, the civil orders that have to do with it? Well, in an emergency room if the number of people waiting for x-ray gets too long, then there are more patients sitting in the emergency rooms waiting to go for x-ray. So, again, even if there's a transport person. If you don't have enough techs, hospitals are incredibly interdependent.

CHAIRPERSON RIVERA: I know and -and some of the nurses have said they've—they'll—they'll and they'll do anything in order to make sure that the patient is comfortable and receiving the services they need. They've mopped floors. They've fixed the television, you know, in order to get that—that-that level that source of comfort for the patient. So, I know that they do it all, and I know that there's also—this is my last question for you is about

drafting—recruiting and retaining physicians. How is that going? I know it's a challenge nationwide, and I know that many doctors come here to train and then go elsewhere. So, how are those efforts going? I know there is also someone here from the Doctors (sic) so, I want to watch the time--

MITCHELL KATZ: Yes, Kevin from the Doctor's Council.

CHAIRPERSON RIVERA: --that is doing great work around this and making sure that our doctors are being taken care of.

MITCHELL KATZ: We've had a lot of success with the recruiting now for physicians based on the recruitment video, and again are we engaged? You know, this is about mission, and there still are issues and again, it's something from my point of view it's about teaching the city system, about the differences just like a doctor, a nurse is not a nurse is not a nurse. A doctor is not a doctor is not a doctor. Right now, we have tremendous problems recruiting psychiatrists because there's a sheer shortage of them. We have trouble recruiting anesthesiologists not because there's a sheer shortage of it, but because other system salaries

were bumped significantly up, and our stayed the same. So, teaching the city okay, it may be true that in general a city negotiates contracts for every three years, but I need the ability if all of the anesthesiologists are earning significantly more across New York City and I want surgery to continue, you can't tell me to wait for negotiations to open. I have to be able to do something today in order to maintain surgeries. Otherwise, again, I wind up losing money because I—I have the surgeon and the nurses and the patient but no anesthesiologist. So, I just wanted to say in general better, but-but there's work to be done, room for improvement.

CHAIRPERSON RIVERA: And we want to be helpful so, I know that we have tremendous talent already here in New York City and I want to thank you for bringing your talents to H&H as well as the team, and this is really just about making sure that we're taking care of New Yorkers, and I know that Health and Hospitals specifically takes care of the poorest. The poorest New Yorkers are our immigrant communities so many, and I want to just thank you, and thank everyone here for their time. I do want to move on. We have some incredible people here to—to testify.

So, thank you for your testimony. Thank you for answering our questions thoughtfully and honestly, and with that, I will call the first panel. Judith Kruchten, Judy Sheridan Gonzalez, Ann Bolle (sp?) Pat James and I want to say it's Patty. Oh, Patty Cane-Patty Cane, Pat Cane. Thank you. Good. Okay, a. That would be great [background comments] and we have plenty of chairs. [background comments/pause] Tell me when you are. [background comments/pause]

ANN BOLLE: My name is Ann Bolle, and I just retired from the city system after 40 years of service at Bellevue Hospital. I am part of the Board of Directors of NYSNA as well as the on the Board of Directors from CPHS.

CHAIRPERSON RIVERA: Ann, I'm sorry to or Ms. Bolle, I'm sorry to interrupt you. We're going to put a timer on just so people have an idea of—Okay? Thank you.

ANN BOLLE: Thank you.

CHAIRPERSON RIVERA: Sorry to interrupt.

ANN BOLLE: Yeah, no. So, basically, I can give you a historical framework in the terms of the staffing. I'm not going to belabor it with what the staffing was in 1978 when I walked into Bellevue

Hospital. I'm just gong to leave that alone, but in the late 1980s we were able to negotiate a contract, and a Safe Staffing program that was developed contractually, and it's been passed out in front of you, and what was done with that was it a joint effort between labor and management and actually there were no lines between labor and management. It was done in a very scientific framework. First of all, it was a patient classification system that looked to the amount of hours that was required to take care of the patients. Subsequent to that, the skill mix was looked to each one of those particular items, and then it was applied to a formula known a s the full-time equivalent. When this was challenged was when they took data for a census, and one of the issues that I head talked about was sick time, and that's the replacement factor, and one of the things that was depleted from that replacement factor in terms of staffing was to account for sick time. So, the idea was is that, you know, initially we accounted for sick time, annual leave time and any time that the-the nurse may have earned, but once you start pulling out sick time, then the reserve just isn't there. The system worked and it worked for a

number of years until we had a mayor whose name shall not be mentioned who did not support New York City Health and Hospitals formerly know as Health and Hospitals. So, he kind of let the system fall apart, but during the years that we had the system intact, there was very little agency and very little overtime, and the system also included a reliability and validity component that established the fact that these numbers were real, and actually I've submitted this to the state in terms of that the governor had in his budget, with regards to the state plan for review in terms of looking at it because, you know, when you say—for example, when you say and IC's ratio should be 1 as to 2, in Bellevue Hospital there's things like continuous renal replacement therapy at the Level 1 (sic) Trauma Center, Echnal (sic) which is also another procedure, and as an adjunct, that's required in a very critical care setting, [bell] requires 2 nurses to 1 patient. So, there—there's a look at what needs need to be done, and what's required by the patient, and subsequently, we evaluate it accordingly. So, I mean I could tell you a lot more. I've been in front of City Council when AIDS was an issue to get more staff, to get more

staff for the critical care areas to acknowledge that CCUs were not just telemetry units, and with a spinal cord injury in terms of making sure that the mid surge areas were appropriately staffed accordingly. So this is not the first time that the City Council as a body heard about this, but it's now your turn to staff it, and hopefully, we'll be able to move forward. Thank you.

CHAIRPERSON RIVERA: Thank you.

JUDITH KRUCHTEN: Good afternoon. My name is Judith Kruchten. I'm the President of the Health and Hospitals Executive Council and mayor agencies in the five boroughs. I'm also a registered nurse of 29 years. Twenty-eight of those years with Woodhull Hospital where I worked as the head nurse in specialty practice. I'm also a lifelong H&H patient. I would like to thank Council Committee Chair Carlina Rivera and Council Members Cabrera and Salamanca for their work on this critical issue. I am here to testify in support of Resolution 396 with amendments. You will hear from my colleagues from around this city why this resolution is so important to the patients of New York City, and I would like to start by discussing the proposed amendments to this bill.

We believe that Safe Staffing saves lives, and we are committed to providing high quality healthcare regardless of the patient's ability to pay. That's why we are committed to H&H, and the following are a few of the amendments that we support and would like to see in the bill. The rest of this is in the testimony, and which you have a copy of. Resolution 396, the resolution calls upon the New York City Council to endorse state enactment of the Safe Staffing for Quality Care Act to ensure that all acute care facilities and nursing homes meet minimum safe staff ratio and standards for nurses and other direct care staff, and further calling upon the City of New York to consider pursuing similar local legislation requiring New York City Health and Hospitals systems and all the providers receiving funding from will contact and supervise services to the city of New York to meet equivalent minimum staffing requirement. Whereas, according to the United States Department of Health and Human Service that the inadequacy of nurses and other direct care staffing level leads to poor patient outcomes; and whereas the National Institute of Health and other research shows that better staff and policies not

only result in better patient outcomes but also lower the operating costs of healthcare providers by reducing the recruitment and training expenses resulting from staff burnout internal work [bell] lowering dependencies and reduce reimbursements, and polls and penalize poor patient outcomes and unnecessary admissions, lowering patients lack of stay, reducing legal and malpractice cause, increases staff productivity due to the lower workplace injuries and fatigue and increasing patient satisfaction, flaws and have some quality arrangement. Whereas, according to the report published by the Health Service Research in 2012, nursing homes, which have safe staff ratios, have better quality of care and, therefore, facilities and improved the functional status of residents; and whereas the Safe Staffing for Quality Act will require all acute hospital and nursing homes in New York State to comply with specific minimum nurse to patient ratios to pass the requirement, submit a faculty staffing plan to the State Department of Health, and require public disclosure of actual hospitals and nursing homes' staffing levels; and be it resolved that the New York City Council calls upon

legislation to pass the Governor to enact the Safe Staffing and Quality Care Act to ensure that acute care facilities and nursing homes meet appropriate minimum staff and ratio to nurse and direct care staff; and be it further resolved that the New York City Council commits to pursuing the implementation of minimum staff based on ratio and standards in New York City Health and Hospitals system and all other acute care hospitals and nursing homes that receive funding from contractors to provide patient care services. I support Resolution 396 as we proposed to amend it, and look forward to its passage. Thank you. Safe staffing saves lives. Thank you for your time and attention.

CHAIRPERSON RIVERA: Thank you.

JUDY SHERIDAN: Hi. My name is Judy Sheridan and I was—-Oh, I have to turn it back?

CHAIRPERSON RIVERA: It’s good. You’ve got it right?

JUDY SHERIDAN: Yep.

CHAIRPERSON RIVERA: Yep.

JUDY SHERIDAN: President of the New York State Nurse Association and an ER Nurse for over 35 years in the Bronx, the county with the worst health

statistics in the state. You know, countless studies have shown that safe staffing saves lives. The most recent study before the Crain's Business evaluated 100,000 patients from 2007 to 2012 and the Columbia University researchers found that the risk for infection was 15% higher in areas understaffed on all shifts. Weakened by illness and trauma, patients die of Sepsis and dysentery as a result of these infections and medical errors are the leading cause of mortality in the United—are the third leading cause of mortality in the United States with over 400,000 deaths a year reported annually, and many unreported and, of course, RNs are the single most effective mitigater of such errors when we have enough staff. So, when we speak about safe staffing, we're not just talking about backrubs, we're actually talking about saving lives perhaps the life of a member of your own family. Morally, wealthy will ensure patients at care front facilities with special immunities units where an adequate staff is provided with secured outcomes. Poor patients in the same facility that was reduced they actually suffer worse outcomes. Staffing legislation would level the playing field demanding all hospitals still hold the

same standards. Safety net hospitals struggle to counter these obstacles but some perform surprisingly well. The Leapfrog Group reported in 2016 that five New York City facilities with the highest rating were actually in Health and Hospitals, which also serves a disproportionate number of uninsured, and provides the most mental health and trauma care and serves as first responder and key promoter of the public health. And financially, the myths of unspeakable costs associated with safe staffing is countered by multiple longitudinal studies, adult studies published in Medical Care estimated that adding 133,000 RNs to the U.S. workforce, which would achieve the 75th percentile of safe staffing and would produce savings of $6.1 billion, and local H&H is far more cost-effective than the private hospitals. It's analyzed comprehensively. [bell] Hidden costs builds upon the co-dependency of the two structures where New York City funds, contract funds. Contracted services and the pays indirect subsidies to private to systems as well as provide hundreds of millions in tax exemptions to them. Such data is elaborated in a 2017 white paper by renowned researchers Barbara Caras (sp?) and James Paris.

Safe Staffing legislation at any government level would assist in creating common ground from which to evaluate the two systems' efficiencies and functioning in addition to providing higher quality care. We believe the passage of the amended resolution 396 would be a critical step, and I just want to make a-a story because one story is really worth a thousand statistics. This is without doing a HIPAA violation. A colleague had a stroke recently, one of our colleagues at Montefiore, and he's brought to Jacobi Medical Center, which is a city hospital. He received excellent care. They saved his life. Immediately initiated appropriate medication and he recovered beautifully. He was transferred to Montefiore where he knew people, was placed in a hallway on a stretcher for hours, and didn't get a bed, and says, Why did they take me out of Jacobi? Just a story.

PATRICIA JAMES: Good afternoon. My name is Patricia James. I'm a registered nurse with Health and Hospitals Kings for 35 years in the Maternal Charge Unit. I serve as Vice President of the Executive Council of Health and Hospitals and Mayoral and as the Vice President of the Local

Bargaining Unit. Thank you to Hospital Committee Chair Carlina Rivera for holding today's hearing. I am honored today to offer my testimony on a topic of serious and dear to my heart, Safe Staffing. In my specific area of work, safe staffing is key for the wellbeing of mothers and families and to all aspects of childcare. Person on staffing level in this section is one nurse for three mothers three babies. That's three beds, which accounts for a total of six patients. Presently in some cases there are five or sic mothers and babies totaling 10 to 12 patients per nurse, which is not advisable for best practice of quality healthcare. A critical aspect of all is a serious increase in maternal and, of course, (sic) mortality rates. We need to pass it to protect patients and save lives. Safe Staffing saves lives. Also the importance is the need for direct care staff to assist mothers and babies at a bedside particularly in cases as the patient undergoes serious infection, direct care professionals help mothers to transfer the babies from the crib from bonding skin to skin and to assist in breast feeding, and provide all the necessary aid in the beginning years of motherhood. New York City Health and

Hospitals is striving to be the premier mother/baby friendly health system, and Safe Staffing helps us to get closer to our family goals of creating a safe environment of overall health including mother and family education such as breast feeding, a component that creates a baby friend environment. We need this staffing to ensure the best possible healthcare in our counsels (sic) for all patients. Evidence has shown that adequate staffing is the correct number of nurses scheduled for the number of patients. Based on areas of specialization or acuity. This leads to better outcomes for patients in our community, including lower mortality rates, fewer readmissions, fewer incidents of harm occurring while in the hospital and better quality of care. Safe Staffing is also better for nurses in the hospitals because it causes (1) better revenue earnings; (2) higher [bell] age cap scores help patient rates and care they receive, (3) good patient satisfaction, (4) good staff outcomes and less stress and burnout, and (5) better staff retention, but the most important thing is that Safe Staffing saves lives. Safe Staffing of nurses and better care professionals, lends itself to more patients' education, which may lead to good

self-management of chronic conditions, decrease emergency room visits, increase compliance of clinic appointment, and adherence of taking their medications. We provide diet, exercise and rest. These can lead only to a better quality of life and a healthier community and may play a crucial role in decreasing maternal mortality. That's why I support Resolution 396, which increase nurses and direct caregivers. Thank you.

PAT KANE: Hi and thank you Madam Chair for addressing this very important issue because have—as you have heard Safe Staffing does save lives, and I believe if we all work together we can really improve healthcare for all of New York and save lives. My name is Pat Kane. I'm Treasurer of the New York State Nurses Association. We are the oldest association and union of registered nurses in the nation, and I'm her today to speak in support of the Amended Resolution 396. I've worked as a Registered Nurse at Staten Island University Hospital for over 30 years most recently in the Open Heart Operating Room. I'd like to say I love the mission of Health and Hospitals, but unfortunately in my borough to serve my community I don't have the option of acute

care of working in one. Otherwise I would be. Just recently as Judy mentioned, Claudia did release a study that supports Safe Staffing, and in that finding there was actually an increase of 15% in infection rates at hospitals that showed consistent poor staffing on the day and night shifts, and that is a very substantial finding. We know from other peer reviewed studies that patient death rates are also tied to nurse staffing. With minimum nurse-to-patient ratios we can provide cost efficient care that improves outcome, and ultimately save lives, and I know you talked a lot about the emergency room, and we heard about the triage and the 1s and 2s, the most critically ill. Well, actually, there are basically ratios in Critical Care on many of our—in many of our hospitals throughout New York where one nurse would typically have no more than two patients. Sometimes the procedures Ms. Bolle talked about there could two nurses to one patient, but in the ER and as 1 and 2s are staying in the ER, there really is an unlimited amount that one nurse can be responsible for, and that's a big problem. The other thing is, and Dr. Katz spoke about keeping nurses on the job, keeping nurses on the job, and with minimum nurse to patient

ratios they will stay. That's how important Safe Staffing is to nurses. So, I want to say if you pass it, they will come. [bell] What make this city great is also our commitment to equality, having a single standard of RN Safe Staffing ratios is ultimately about equality, equality care in acute hospitals public and private so that all patients receive care from the bedside nurses working the frontlines of care. That's the same, and what indicator of equality could be more meaningful than a care ratio linked to mortality rates. but today, unfortunately that fundamental equalizer care governing the lives of New Yorkers is totally out of whack, and we must work together to change that. So, we also ask for your support for the resolution put forward today so that the Legislature and Governor will hear your voice. The voice of the New York City Council, as we all know, is heard not just in Albany but throughout the country, and that is how important your role is on New York City Council. With a vote for this resolution you stand for equality, fundamental equality so that every New Yorker no matter what her stature, wealth or position will receive proper care from hospital nurses working

according to professionally supportive minimum nurse-to-patient ratios in all of our hospitals. Thank you very much for the opportunity.

CHAIRPERSON RIVERA: Thank you. I just have a couple quick questions for you all. You're going to hear some testimony today should you have the time to stick around, and I want to thank you for all the time you've given this committee already, and that—that a strict ratios is not the way to go. Do you think there's alternative way to achieve Safe Staffing practices without implementing the strict ratio? I had a feeling you would be able to answer.

ANN BOLLE: Well, if you look at what I gave you basically it came to ratios, but they were, you know, amendable because you were looking at the acuity level most directly of the patient so that in terms of understanding certain things with regard to treatment modalities that required a certain setup in terms of nurse to patient ratios and it was allocated by-by that acuity system that was then later tested by a reliability and validity framework. Sometime just by the advance of new technology you know that some—I mean I worked at Bellevue for 40 years, and as technology changed through the years, like for

example most recently CRR2 just continuous renal replacement therapy is done in the ICU. That patient in that ICU has two nurses on that one patient to—to handle the complexity of that equipment, and also ECMO in terms of a CD Pack with regards CD PACU (sic) with regards to once again 2 nurses to 1 patient. I also want to dovetail something that I didn't mention earlier, and that's the idea of recruitment and retention. I mean when I started at Bellevue, I was making—now this is 1978—I was making $12,000 a year. If I had worked at the old Beekman in downtown, it would—I would have made $16,000. So that was a significant amount of money, but what kept me at Bellevue was the mentorship, the training, and the availability of resources, and the belief in the system that—that came to me, and one of the things that's lacking in today's world is to why we're losing young nurses is they don't have the transition in terms of the educational process. Now I noted there's a beginning Mentorship Program, but it's connected to NYU and Columbia, have CUNY and I'm a graduate of CUNY times 3 (sic) and I'm extremely proud of the education that I got, and the education that I saw public sector to public sector. We

shouldn't be getting money out of the system. We should be keeping money in the system, Lehman, Hunter all the CUNYs. When you look at their pass rate on the boards and you start comparing them to the private sector, there is no comparison. So the transition need to be worked upon. You need to augment your Staff Development Department, and you need facilitate a training process that actually was established and has been chipped away through the years, but I'm sorry CUNY to New York City Health and Hospitals there is no better match, and—and why I'm bringing that up today is because I do a little program at Bellevue where I try to do that kind of bridge thing, and I name it after someone who mentioned me. Okay, but a nurse walked in who I taught 25 years ago, and he was in that same student nurse program. So, it worked. It's dedication and commitment, and it's why I got to go. I'm going to work a year there. Well, I don't know what happened, but 40 years went by, and I'd still be there except, you know, I'm—I'm 53. [background comments]

CHAIRPERSON RIVERA: Thank you.

JUDITH KRUCHTEN: Well, I just—I just wanted to talk about a little bit about the flexibility issue--

CHAIRPERSON RIVERA: Yes.

JUDITH KRUCHTEN: --because first of all, I think you really need to read the legislation because this again sets a minimum standard and in healthcare I think most people know this is a very well regulated sector, and we have a lot of minimum standards. So, there actually is flexibility in the legislation to deal with things like Ann talked about, and the other thing I want to say is this is a staffing plan, right. So, it provides for a number of nurses. It's very specific for the type of care going on in a unit, but within the nurses and among ourselves we do this all the time in terms of how we split that up, if a patient becomes critically ill, I mean you often see four nurses run into that patient's room, and that continues to happen and that's—that's just the way as Dr. Katz said and others have said we work as a team. So when people say that this is a very strict ratio, it actually isn't if you look at the—if you look at the actual legislation and if you look at the actual way that we

work, but this provides with a staffing plan that—that would mandate at least a number of—having a number of adequate nurses in that unit so that we can deal with things that do arise, as they will. Nobody can certainly predict what's going to go on sometimes from minute to minute, but certainly there is flexibility in this. And just to add, you know, we're a society which has standard everywhere. Why do we not have standards in nursing care, right? Why is that the one area where we can't have real standard. We're talking about a minimum number just like if you passed a test you need to have 65 to pass a test, but people room almost all the way to the 100. You can't be a lawyer unless you graduate law school. We have minimum standards everywhere. This is a minimum standard to allow for anything that can happen, and these are hospitals and anything can happen, and does happen all the time. So, this minimum standard just provides a floor from which we can move things around so we can save lives. So, when four nurses have to go in that room to resuscitate that patient, somebody else has exsanguinate in the next room because there's nobody there for that person. We have to have enough of a cushion so that we can save lives

when those things happen. That's really what it is. It's all about minimum standards and totally—totally flexible.

CHAIRPERSON RIVERA: Yeah, and I want to also thank you for—for mentioning about retention, and like if we have Safe Staffing, nurses will stay. They have just a better work environment. They're able to support their colleagues, and again it's a mission that typically brings nurses to public sector anyway.

ANN BELLE: I mean my fear is that, you know, everybody talks about the other—it's all New York. I mean I go there and, you know, I have insurance, you know, and, you know, it's some—I'm actually second generation to the system because I grew up hearing that, you know, about access to care, and about how open the system is, and—and everybody has equal—equal chance, and—and there's no other system that's better than that in the city, or in the country unless there's another public sector system that mimics what HHC does, but—and New York City Health and Hospitals, but it's the idea of the support that we give each other, and with the new graduate they need the support, they need the

contact, they need the person there that they can run to if they don't feel secure in what they're doing, and that's really also what's lacking in the system right now.

CHAIRPERSON RIVERA: Well, thank you so—and what's the name of your mentor that you named the program after?

ANN BELLE: Margaret Whitehorn, and she was a Bellevue and she as a Bellevue School of Nursing graduate.

CHAIRPERSON RIVERA: Well, thank you all. Thank all of you so much for your time and thank you to—to Ms. Whitehorn as well for her mentorship. Thank you everyone. [applause/background comments/pause] Okay, I'm going to call up our—honored to have our—the New York State Assemblywoman for the 87th District, Karines Reyes. I'm also going to call up Julissa Saud

JULISSA SAUD: [interposing] Saud.

CHAIRPERSON RIVERA: Carolyn Esposito, Ari Boma, Alicia Meyers, and Leon Belk. [background comments/pause] Are you ready?

KARINES REYES: Sure. So, good afternoon, Chairwoman. Thank you for having me here,

and thank you for allowing me the opportunity to share my testimony with all of you today. My name Karines Reyes, and a registered nurse and Assembly Member for the 87th District in the Bronx representing the neighborhoods of Parkchester, Van Nest, Castle Hill and West Farms. Just days before I walked the halls of our state capital in Albany, I was a full-time staff nurse in the Oncology Unit in Montefiore's Weiler Hospital in the Bronx. My experience caring for the sickest members of my community were the impetus that made me decide to run for office. It's impossible to deny all the incredible medical advances that help us identify and treat diseases sooner, and help people live longer. However, these scientific advances can never supplant the human aspect of healthcare. I would like to illustrate for you a typical 12-hour shift for a nurse—what a—for a nurse. So, my day would begin at 7:00 a.m. with a brief hand-off report from the outgoing nurse, and he and she—he or she would update me on the overall medical history of my patients, the current problem or reason for admission, the plan of care, any medical interventions that have happened while admitted, any intervention that took place in

the past 12 hours, any pending intervent— interventions that I have to execute during my shift. I would then preform a thorough assessment of my patient to establish the baseline at the time of hand-off and this includes vital signs, also locating breast and bowel sounds with my stethoscope, assessing circulatory status, and I want to add that this is often the best way to identify small bowel obstructions, beginnings of pneumonia, pulmonary embolism even before a patient becomes symptomatic. So, it's important to note that these are some of the most common and often deadly post-surgical complications, and under these circumstances, early detection by an experienced clinician can be the difference between life or death for these patients, and then I would continue my assessment. I would verify IV drips to make sure they're consistent with doctor's orders; assessing medical equipment connected to the patient, and physically inspecting any wounds or dressings that a patient may have, and lastly, I would document my findings in the EMR, the electronic record, and I would do this for every single one of my patients assigned to me, and my patients consisted of anywhere between five and eight

patients varying with different degrees of acuity. So, imagine that while I try to complete my baseline assessments, the call bells are going off. Patients need to be helped to the bathroom or need to be medicated for pain or transferred to a stretcher because they have to leave the unit for a test, and simultaneously the kitchen brings ups the breakfast trays, and many of my patients aren't able to feed themselves. So the food will sit in front of them until someone has the time to feed them, and by 9:00 a.m. I have to have to have a review of all my patients' labs and by 10:00 a.m. I need to begin preparing and administering each patient's medications. Some patients they have tons of medications including multiple IV infusions due by 10:00 a.m. So, my day would continue at this space—to this pace with very little room for error. It was an emergence—if there was an emergency that interrupted this very tight schedule, every patient under my care would feel the brunt of it, and my fellow nurses would have to pitch in at the expense of the patients under their care. So, when we say that Safe Staffing saves lives, it's as simple as that. It literally saves lives. So, the Journal of

the American Medical Association published research that estimated five additional deaths per 1,000 patients occurred in hospitals that routinely staff with a 1 to 8 nurse to patient ratio compared to those staffing with a 1 to 4 nurse to patient ratio, and the odds—and the odds of patient deaths increased by 7% for each additional patient the nurse must care for at one time. So, as a legislator, I am tasked with the responsibility of weighing in on the State Budget. We spent the beginning of this year fighting back cuts to Medicaid funding, and because CMS reimbursement is tied to patient outcomes and satisfaction scores, Safe Staffing makes fiscal sense. The Agency for Healthcare Research and Quality has found that hospitals that lower nurse staffing levels have higher rates of pneumonia, shock, cardiac arrest, urinary tract infections and upper GI bleeding—bleeds leading to higher costs and mortalities from hospital acquired complications. Research shows that better staffing policies not only result in better patient outcomes, but also lower the operating costs of healthcare providers by (A) reducing the recruitment and training expenses resulting from staff burnout and turnover. (B)

Lowering the penalties and reduce reimbursement opposed to penalize poor patient outcomes and unnecessary readmissions. (C) Lowering patient length of stay. (D) Reducing [bell] legal malpractice costs. (E) Lowering staff productivity due to workplace injuries and fatigue, and (F) Lowering patient satisfaction scores and patient hospital quality rating. So, Safe Staffing is the single most important thing we can do to ensure the safety and care of every patient in our state. There is not technology that can help us better improve patient outcomes without addressing staffing. Dr. Daniello restated in a New York Times article just last week: Corporate medicine has milked just about all efficient—efficiencies it can out of the system. With mergers and streamlining it has pushed their productivity numbers about as far as they can go. Healthcare is not an assembly line. We need to do—we need to put the bodies in place to do the work of taking care of our loved ones because we have to remember that at any given time that patient could be a mother, a father or children or us, and I support the Resolution 396 with the amendments that my

colleagues have suggested, and I'm here to, of course, show their support of that. So, thank you.

CHAIRPERSON RIVERA: Thank you. Thank you so much for—and for everything you've done in Albany this past session, the last. [applause] It's—I mean it must be right, awesome to have a nurse in the Assembly. It's pretty cool.

KARINES REYES: Everything is about staffing.

CHAIRPERSON RIVERA: Yes. Okay, thank you. Thank you so much for your time. I—I mean to have that direct report of-of being on the ground and knowing what it's like, and—and to your colleagues' point of—of having—this is a fight that has been ongoing that we're just trying to make common sense of when we all know healthcare is a human right, and we as a model city we deserve to—better outcomes. So, thank you. Thank you for being here. Thank you for your testimony. [background comments/pause]

ARI BOMA: Good afternoon. My name is Ari Boma (sp?) I've been working—I've been working as registered nurse at in the Department of Psychiatry at Interfaith Medical Center in Brooklyn for 23 years. Thanks to the Chair—thanks to Rivera

for for highlighting this very important issue. I'm here to testify in support of an amendment to Introduction 396 and support of Intro 1352. Interfaith Medical Center is located in Bayside in Central Brooklyn and it is one of the sickness hospitals caring for vulnerable New Yorkers. If I might digress a little bit, a safe—a Safe net hospital is a type of medical center in the U.S. by legal obligation or mission to provide care for individuals regardless of their financial status or obligation to pay. Apart from the city hospitals, Interfaith is the largest psychiatric hospital in Central Brooklyn. A first year report on Health Disparity in New York City published by the NYC Department of Health and Mental Hygiene many have problems generally among the cohorts in Brooklyn. Further more, in the Committee Health profile of 2018, the rate of psychiatric hospitalizing in Bed-Stuy in higher than the city rates posting a 1,000 and to 100,000 adults completed city outreach of 676. This reflects the challenges residents in the under-resourced neighborhood face including difficulty assessing preventive statuses on other care, greater exposure that—that individuals of greater exposure to

stressors and interruption in their healthcare, and more also there are 2 to 6 times more likely to experience serious emotional stress than those with the highest income. My honorable Council Members, do you know where they go when or I mean [bell] where they go to seek care? [background comments] To see illness after the—the emergency services to break it if they dare head to the emergency room. The Safe Staff for Safe Staffing for Quality Care ensures that aftercare facilities and must impose making the more safe staffing ratio and standards for notice and better direct care. This would greatly impact an emergency department where many of our patient, where patients are forced to wait for a bed to become available where they also go to seek their first care because they could not afford to go to other—or them to seek the advice of private doctors. When such—when such aftercare patients are forced to wait in the emergency rooms it becomes imaginable. Many patients have behavioral also that lends to their mental image, which they find in a wide spectrum. We credit ED long waiting staff and doing test levels. (sic) So, I think to those patients, and give them our professed attention, it becomes a daunting

situation, and it certainly stand for notice and there is justice by that. Believe me, I'm speaking from the spirits of two to three years. I support the Proposed, too, for a Local Law in relation to conducting a study by the Department of Health and Mental Hygiene on the cases of rising wait times in emergency room. I believe the shortness on staffing has an impact on wait time. In 2004, California passed a staffing law, which required hospitals to instate one nurse to two patient ratios. Where studies are showing that the system in California has reported improved patient care patient care outcomes, and lower work—workers' injury rates. Workers injured in the psychiatric units are more common, and then had issues of less shortage. When it aggravates as second level for all direct care staff to ensure the safety of everyone on the psychiatric unit, as the patient population needs and deserves this addition. What I spend my—what I spend my time doing for patients differs and depends on staffing levels. We are usually short staffed, and it is our patients that suffer. We are unable to give them time and attention to detail they require. Please, ascertain from dealing with these patients first time. The

mind is a terrible thing to lose, and as nurses we have taken an oath to protect and to care for that, the importance of stressful and guilt feelings where you couldn't give the patient the care he or she deserves because of shortage of staff. It is agonizing when you give your best, like you're working in love because you couldn't to the defense of your 20th patient. Please. I support and encourage you implement of an amended of a special health solution treatment which includes all direct care staff ratios. Thank you.

CHAIRPERSON RIVERA: Thank you for—for mentioning or psychiatric patients and I know behavioral health has been a very, very big issue, and unfortunately so many of these patients are—end up in the emergency room when they need so much more focused care and attention. And just so—as a friendly reminder, everyone, we want to just stay close to the clock so we could through all of this testimony. So, thank you.

JULISSA SAUD: Thank you. Good afternoon. My name Julissa Saud, and I'm an Adult Geriatric Nurse Practitioner. I have been working with NYC H&H for 16 years, 11 of those years have been spent in

the Pediatric Department specifically ambulatory care at Elmhurst Hospital. Thank you Chair Carlina Rivera as well as Council Members Cabrera and Salamanca for today's hearing of the important work on this issue that clearly impacts New York City patients. I am testifying I support of the Amended Resolution 396 and in support of Resolution 723. When I worked as a Pediatric Nurse care for our most vulnerable patients, our patients ranged from 7 days old to 17 years old. They all had different needs and concern related to health. Working in the clinic our primary goal is prevention. We want to prevent those hospitalizations of these patients. Being that you need time to educate patients. You need time to give vaccinations. You need time for those patients who walk in for a regular clinic visit. We need to add the treatment. However, our patient load was so great due to short staffing we would have 20 to 24 patients to see on 7-hour shift. So, therefore, our time to educate patients from 30 minutes, we're down to 15 minutes on that. So that left the newborn mother with—with problems breast feeding with questions. That patient that maybe needed a helmet to prevent a head injury without a helmet. These are

part—services that some of our H&H facilities provide for prevention or due to short staffing we weren't able. Along side us we have our nurses in the Pediatric ED. They receive 12 to 13 patients per shift. In PC (sic) they would take more. So guess what, those patients were diverted to the clinic. We would have to set up a triage area in order to triage those patients, but we were short staffing in inpatient. If those patients had to be admitted, they would wait an hour or an hour and a half in our busy clinics. So, along with the patient having 20 to 24 patients she would now also have to reserve that patient to have to wait to be admitted into the unit due to short staffing. [coughs] the Safe Staffing for Quality Care Act ensure that acute care facilities and nursing homes the appropriate minimum—minimum staffing ratios for nurses and direct care staff. As the New York City Council commits to pursue an implementation of minimum [bell] Safe Staffing ratios and standards in numerous- NYC Health and Hospital system and all of our acute care hospitals and nursing homes not receive funding from or contracted to provide patient care services for the city of New York. Safe Staffing gives new parents

time for education, gives time for them to learn how to care for their sick children. Babies who cannot or advocate for their own needs, can lead—care for their deaths and illnesses related to—related to education and prevention. We are not begging for money we are begging to save lives. We are begging for the opportunity to go home and feel like we did a good job by our patients, and not have to worry if we forgot anything. There will always be excuses for short staffing, but I guarantee you those who oppose Safe Staffing for Quality Care Act minimum have never walked on—on me and my colleagues' shoes at NYC H&H. That's who showing support and encouraging the implementation of the amended version of Resolution 396, which includes all direct care staff ratios. I also support Resolution 723. Thank you.

CHAIRPERSON RIVERA: Thank you.

Olivia MCMYERS: Good afternoon. My name is Olivia McMyers. Thank you Committee chairwoman Rivera as well as Council Members Cabrera and Salamanca for your work on Resolution 396. I'm testifying in support—in support of Resolution 396 with amendments. For the past 27 years I've worked was a registered professional nurse. 22? That's 27.

Having staff H&H Harlem. I'm moving through the ranks from staff nurse to Nursing Supervisor and now Accountable Care Manager. My background is specifically critical care an emergency services. I've been on the frontline as a direct care provider. I'm knowledgeable about the challenges that many direct care RNs face, but specifically now I'm also the NYSNA LBU Member Chairperson for all the new nurse events at H&H Harlem. So, I have the distinct privilege of welcoming events, orientating them to being a newly hired RN and an NYSNA member. I tell them about the advantage of being an H&H nurse. I tell them that their experience will take the anywhere. I also tell them that this line of work is a labor of love, but it can be extremely rewarding. I just want to relay a little story about a specific unit. Our Cardiac Care Unit is a six-bed critical care unit. There's usually lots of patients with severe heart conditions. They require continuous heart and rhythm monitoring. Some patients have breathing tubes in their arm, breathing machines for them. Most patients require complex medications to control or regulate their blood pressure or blood sugar, which can only be given through an IV pump

while being monitored continuously. There are times when patients have critical procedures like Amber already mentioned already mentioned being performed hourly such as focus on their blood or urine or cooling down their bodies after their heart has stopped and they've been revived successfully. Critical Care patients are admitted into Critical Care Units because they need intensive care, and monitoring. They're not just bodies. In the same Cardiac Unit within the past year we've had three new RNs hired. After four months one came to me with express concern about staffing working short. She resigned. What could I say to her. I try to tell nurses that we're striving for better outcome. A second nurse came to me four months after the first and stated that she, too, was going to resign. She expressed concerns about working from 7:30 to 9:00 and being unable to document properly because she failing her plan spot. (sic) To express her frustration openly as a person who's taking care of possibly 1 to three patients in a 12-hour shift or 4 to 5 if you're working nights. I convinced her to say for another month, but after a while she, too, was overwhelmed, underappreciated and too stressed to

continue this pattern. She resigned as well. I orient members to the facility as a new member. I speak to seasoned members also, and have heard many nurses talk about how difficult it has become to provide the quality of care our patients deserve . They're tired of working short. They're tired of working alone and 11.5 hours without having a meal break or a bathroom break, and I tell them it will get better. It's truly a labor of love, but now we need the City of New York to express that labor of love to our nurses, direct care professionals and patients that we care for. Safe Staffing saves lives, and that's why I support and encourage the implementation of the amended version of Resolution 396, which includes nurses and all direct care staff. Thank you.

CHAIRPERSON RIVERA: Thank you.

DR. CAROLYN ESPOSITO: I'm Dr. Caroline Esposito. I'm a registered nurse. I am a former defense malpractice attorney. I'm an educator. I'm currently employed as the Director of Nursing Education and Nursing Research at the New York State Nurse's Association, and in that role I conduct independent studies into the RN staffing levels at

the 165 hospitals and nursing homes that we represent through collective bargaining. NYSNA overarching finding is that only 2% of its facilities currently meet the proposed staffing requirements that are advocated in the Safe Staffing for Quality Care Act, and only 4% of them meet our contractually agreed to nurse to patient ratios. NYSNA has found that through its POA review it's in negotiations and it's independent studies, and I say this—I say this from an ethical perspective from my personal ethical perspective that our healthcare facilities are consistently deliberately and conscientiously understaffing their patient units. They're refraining from filling budgeted positions and they are routinely posting schedules with no holes in those schedules. The relationship between staffing levels and patient outcomes have been studied apparently for over 25 years, and there's a plethora of research findings and even a study by the CMS that shows increasing negative patient outcomes associated with lower RN staffing levels. Now, I'm not going to repeat testimony. A lot of it has been given. I do refer to you to the testimony that I submitted. What I'd like to talk to you about now are those protests

of assignments that I review on behalf of the nurses and—and the hospitals that we represent. We just concluded studying the private sector hospitals and, you know, with all due respect to Dr. Katz, [bell] the critical care areas are not the number one area that nurses are filing protests over. It's the med surg units, and I am a former med surg nurse so I know what the—what the work is like and how difficult it is. NYSNA gets about 30,000 protests of assignments by year. Each protest of assignment is signed by four to six nurses. So you do the mathematics there. We consider that each signature is a separate protest of assignment. So, we have tens of thousands of nurses who are complaining about the quality of their nursing environment, and they're begging for the Safe Staffing for Quality Care Act to be passed in order to help then do the job that they are ethically and legally required to do. Nurses our vanguards of patients' safety and patient care, and without this minimum staffing that's in our—our bill, nurses are not able to perform the function that they are again ethically, legally, socially required to do.

CHAIRPERSON RIVERA: Thank you, Dr. Esposito. I'm glad that you mentioned the protests. I-I have met with nurses who have told me about the protest. It's kind of like a common piece of paper they now give, and they don't feel the process itself is taken with the seriousness of which that documentation implicits. I wanted to ask are there specific departments we're setting a specific nurse to patient ratio is the most critical. Now what I appreciate about this panel is the diversity of in the field, right. We've heard on pediatrics and oncology and psychiatrics. So, is there one particular—I don't want to say one. I'm not trying to limit it, but are there specific departments where it's—it has to happen. It's—it's-it's really, really critical. You mentioned that med-surg are--

DR. CAROLYN ESPOSITO: Med-surg, and look, the reality is every specialty nurse and care unit needs the ratios, every one, but what I see consistently in the protests of assignment is that the number one units that submit the most protest of assignments are the med-surg, the Critical Care Units, the Emergency Department, Telemetry Stepdown and Psychiatry. Now, they vary in order, but I would

say generally speaking med-surg is the number one area--

CHAIRPERSON RIVERA: Okay.

DR. CAROLYN ESPOSITO: --where nurses are crying out.

CHAIRPERSON RIVERA: Thank you. I appreciate that. It really—it really does mean a lot when can give detail and nuance and just is lots of your experience and what you're dealing with on a—on a daily level, and thank you for your experience, and—and what you're now. Thank you. Thank you everyone. Thank you for your time. With that, I'm going to call up the next panel. Lorraine Ryan from Greater New York, Migna Pavaris from Arch Care, and Scott A.M. Hinds—A.M. hinds. Folks, Continuing Care Leadership Coalition. [background comments/pause]

LORRAINE RYAN: I'm not sure if this is on.

FEMALE SPEAKER: Yes.

LORRAINE RYAN: Thank you. pause] Shall I begin?

CHAIRPERSON RIVERA: Yes.

LORRAINE RYAN: Good afternoon, Chair Rivera and Council Members. We're still here. Thank

you so much for spending the time that you have on your really tremendous questions throughout the afternoon. My name is Lorraine Ryan. I'm the Senior Vice President of Greater New York Hospital Association. Our members include every hospital in New York City as well as hospitals across the state, and we're New Jersey and Connecticut and Rhode Island. As I just thanked you, I will thank you again for the opportunity to speak at this hearing today. New York Hospitals Greater New York, and I as a nurse have the deepest respect and admiration for out registered nurses, and you might find this surprising, but we support more nurses, and we understand the need for more nurses to ensure that our patients get the absolute best care that they possibly can, but we do not support, however, is forced and flexible nature of the staffing ratios bill that has been put before the State Legislature for the last several years. And I just want to correct one point that the bill that has been entertained in Albany is a—is a bit more severe than what California actually did pass specifically in the area of med-surg. California passed a bill that allowed for 1 to 5 ratio as the New Bill calls for a

1 to 4 ratio. So, the bill is what we oppose. We do not opposed more nurses. My responsibility to Greater New York include oversight of our clinical quality improvement initiatives and programming and I can say without reservation that our hospitals are deeply committed to doing the best they possibly can, and to constantly improve. We understand very well where we need to improve and there are initiatives underway that are devoted to that level of improvement in a multi-disciplinary manner, however. No two hospitals are exactly the same, and no single staffing formula at all times works in every situation. Legislating and mandating such belies the proven ability of hospitals and union to agree on staffing plans on their own through good faith negotiations as was done recently in New York City with NYSNA. Again, I have to reinforce that it's the inflexible nature of the bill. Yes, you can add more nurses, but you cannot add more patients, and when you have three patients waiting to go home on a med-surg unit, and one patient that is staying and you get three admissions, that nurse cannot take those admissions, and I think it needs to be well understood that acuity and senses is an imperative

ingredient to a safe staffing plan. That is not considered in the bill. Forced nurse staffing ratios, and we've heard this earlier today, would crowd out essential members of the healthcare team, undermine real time patient care decisions, and again, deny hospitals and leadership as well as unit based nurses who participate in professional practice committees. The flexibility they—that they need both to plan for staffing needs and to respond to emergencies. Healthcare delivery has never been more complex. We've heard that today over and over again, and we have learned that the only way [bell] to ensure optium—optimums of care is through a multi-disciplinary team approach. Not only nurses and physicians, but physical therapist, dieticians, pharmacists, transporters and I could go on and on, but I won't. Mandatory ratios that need to be met at all times will prohibit the ability of this team to function as it should. I have a lot more to say. Since there's only three of us can I go on for a little bit longer?

CHAIRPERSON RIVERA: I'll give the--

LORRAINE RYAN: A couple minutes?

CHAIRPERSON RIVERA: That's—that's fine.

LORRAINE RYAN: You know, the cost of the bill is prohibitive. I don't know if that's, you know, it's—it's out there as a $3 billion annual cost for hospitals and nursing homes, $2 billion for hospitals. Currently the Department of Health, as you know, is studying the impact of—of what we need in healthcare today in New York looking at the fiscal side as well as other initiatives and enhancements to staffing that will lead to better outcomes. I can address some of those now or in my—in the Q & A section. We talked a little bit about quality of care is a team sport these day. I hate to call it a sport because it's a very serious commitment that we make as clinicians, and its healthcare providers, and there are studies that demonstrate improvement through the use of evidence-based practices that a multi-disciplinary team implements. I will reiterate that leaving staffing decisions to the experts with the input of unit based nurses is essential. We want to hear the voice of the nurse who's taking care of these patients each and every day who understands the challenges, and again the negotiations with NYSNA have been so successful in getting more—getting more actual nurses on the unit, filling vacant positions,

having a large numbers of incremental staff across those hospitals that have already negotiated and those that are currently underway based on census, implement throat pools to respond to sick calls an unexpected absences, which you can't always anticipate or plan for. Agreed to enforcement of staffing guidelines to address systematic failures, and meeting those guidelines, use of a third-party mediator, and dispute resolution procedures when and if necessary. These are all essential. These are important steps. It's tremendous and I think we all applaud the efforts of-of those who have successfully negotiated. I'm not going to play, you know, back and forth on all the studies. The studies go both ways. It is not absolutely clear and certain. California will tell you that themselves. Staffing has not improved care across the board in all settings. In fact, the President of the SEIU, United Health Workers West says that it has not improved care as recently as 2015, and that there's no reliable evidence that nurse/staffing ratios will do that for you. The study that the Department of Health was mandated to conduct is underway, and it's very important to look—you asked about best practices

earlier in the day. There are lots of best practices we could talk about that will get us where need to go, get everybody in this room where we need to go without fixed inflexible ratios. What it would do to threaten other jobs other than nurses within the healthcare environment is I think very obvious, and we've spoken a bit about that today. As far as ED wait times, I think it needs to be well understood that the at all times inflexible requirements of the legislation will increase wait times. You will not be able to get patients our of the emergency department because a nurse in a med-surg unit cannot take one more patient under the law. That is not where we need to go. We've worked very hard for the last five years with support from the federal government to reduce ED admissions, if you will, patients being admitted from the ED and diverted to ambulatory care. We're taking better care of our patients in the settings where they need to be cared for. It was raised earlier by one of the other Council members that patients only get sicker when they sit in emergency departments and are surrounded by patients who are actually sick when their—their issue may not actually require and inpatient setting.

And finally—where's my final speech? I don't know where it is. Here it is. We have rules that already exist. You've mentioned them yourself earlier today, the New York State Regulations 405 require nursing leadership to staff to the appropriate number and type of personnel needed to ensure safety. There are federal accreditors that are deemed to go in on behalf of CMS, and they—they survey to the quality and level of staffing, and there are also other requirements in New York State Law requiring the disclosure of staffing plans to anyone who asks, and they're associated with quality outcomes. In conclusion, we believe that staffing are left best to the experts, experienced clinicians, and for these reasons and all of those cited in my written testimony as well, we oppose the bill that has been entertained in Albany is now submitted is now being discussed at this hearing today. Thank you.

CHAIRPERSON RIVERA: Thank you.

MIGNA PAVARIS: Good afternoon Chairwoman Rivera and members of the Committee. It's an honor to be here this afternoon. I'm Migna Pavaris, and I'm the Director of Business and Strategic Planning for Arch Care. Thank you for the opportunity to

testify today regarding our concerns regarding mandatory staffing ratios. Arch Care cares for people of all ages based where they are most comfortable and thus able to receive it at home, in the community and in nursing homes. As the continuing care community of the Arch Diocese of New York we see enhancing the lives of our elders and others who need extra help to stay healthy and live life to its fullest is more than just a job to us. It's a privilege and our calling. We strive to provide the highest quality of service to our patients. It is integral to everything we do including how we staff our nursing homes. We have been able to provide five star quality across many of our nursing homes, and received national recognition for our achievements. It's important to understand that within our nursing homes there is a wide range of acuity levels, and in this context acuity means someone sicker than others, more clinically complex whereas some are completely stable. We have young people in our facilities that have no place else to go that have minimal care needs. Housing is a real problem in their situation not medical care. So, and you can't discharge someone onto the streets. So,

mandatory patient staffing ratios limits the flexibility needed to achieve high quality and distracts from patients who have medical needs. It would be a failed policy enactment to not consider these complexities. This required change called for within this Resolution will negatively impact the provision of specialized care an therapy. The ecosystem of this type of facility needs to be properly assessed and considered coupled with patient care needs and balanced with the reality of financial resources to support the various needs and functions of the institution providing the care: Housekeeping, food services, various therapies, doctors, social workers, security guards among other professional service providers all roles that contribute to the overall patient health and are key members to promoting success-successful patient healing. [bell] Prescribing a mandatory staffing ratio fails to consider to the clinical care team needed to support a patient to its healing. It will cost Arch Care upwards of $23 million to implement the proposed nursing staffing ratios, which will not be covered by the reimbursement rates we currently receive. This proposal would virtually ensure the complete

privatization of the nursing home industry despite the fact that studies have demonstrated the non-profit nursing homes provide higher levels of quality. According to a Harvard study when compared to privately commercially owned nursing homes, non-profit nursing homes decrease hospitalizations by 9.5% increase mobility improvement by 12.8% and increase pain improvement by 19.9%. Similar to—similar legislation in California the law excluded nursing homes. If enacted, this change would be a $10 million unfunded mandate to nursing homes. Nursing homes already operate on very small margins, and are currently monitored by New York State DOHMH and CMS. CMS recently modified their surveillance rating system for nursing homes. The update policy holds operators accountable for staffing ratios. CMS request that person—requests personal—personnel and benefit data to be provided to them directly. The staffing information allows them to know how nursing homes are staffing their units. If staffing levels are not reached, CMS automatically reduces the facility's rating to one star. I think it would be prudent to allow CMS' rating system to take effect and to affect the outcomes that we're trying to

achieve through this legislation. The proposed nursing—nurse staffing ratio legislation is a one-size-fits—all prescription for nursing homes that will bust their reputation (sic), care and quality. This approach does not recognize the wide range and complexity of patient needs. Our nursing homes provide skilled nursing care, physical and occupational therapy, medication, nutrition, mobility and spiritual care. Arch Care is committee to providing all of this care, and caring for the whole person. A funded mandate is one thing, but an unfunded mandate will potentially fail our most vulnerable New Yorkers. Thank you.

CHAIRPERSON RIVERA: Thank you. Can you people just try to stick to the two minutes?

SCOTT AMRHEIN: Is—is it three or is it two?

CHAIRPERSON RIVERA: Whatever is up there.

SCOTT AMRHEIN: Very good.

FEMALE SPEAKER: Thanks.

CHAIRPERSON RIVERA: Yeah.

SCOTT AMRHEIN: So, just and Chairwoman Rivera My name is Scott Amrhein, and I’m from the

Continuing Care Leadership Coalition. I'm very—I'm pleased and grateful for the opportunity to testify. I'm going to try to certainly not read my testimony and sort of emphasize some of the points that many have made, and--

CHAIRPERSON RIVERA: Appreciate it.

SCOTT AMRHEIN: --and the—the first is—is, you know, they're a member of CCLC and all of our members are—are very supportive of the goals. You know the goals of achieving better care, the goals of achieving better jobs, a better environment. The thing that we take issue with is the way of getting there. We heard the word standardization, and we believe in standardization, but I think what we would support is more standardization of approach than the kind of standardization that says there's one specific number in all of these different organizations that can be applied very simply and I think as you heard many of them say, you know, the nurses, and it's my kind of point that I want to start with is the nursing homes in the City of New York and the State to New York are very diverse. They have programs that range from wound care to bariatric care, to IV therapy to ventilation. We

have services for people with Huntington's Disease. You know, it's a very diverse community, and to set one staff ratio for that widely diverse community I think everyone can appreciate why that doesn't make sense. The other thing I wanted to raise that I think may not be that well known is that the agency that oversees nursing home quality really struggled with these issues, and in 2016 they did for the first time in about 19 years a whole new revamp of the regulatory structure of nursing homes, and in the proposed rule, and I encourage people to read it, they really raised the pros and the cons of fixed ratios versus alternative approaches, the just ultimately decided that fixed ratios were too inflexible for application in the nursing facility setting. And again, I won't read it, but there's language that—that basically says the do not necessarily agree that imposing such a requirement is the best way. Rather, the focus should be on the skillsets and the specific competencies of the assigned staff to provide the nursing care or resident needs rather a static number of staff or hours. What they ended up doing was implementing a new model regulation nursing home staffing that

require the competency based approach. So, as—as was said, every nursing home has to assess the acuity of the residents, come up with a staffing plan, and then be evaluated on that plan and that's part of the [bell] survey process. And the last thing I'll say, and I think it was alluded to is, you know, I stay awake at night every night worrying about the survivor of high quality not-for-profit nursing homes. We have nursing homes closing one every two months and the nursing homes that are closing the most are the highest quality not-for-profit providers, they simply aren't paid enough that a Medicaid system as it is to thrive, and if you impose a mandate that, Lorraine indicated is equal to a billion dollars a year for the nursing homes in New York State, you're going to see an acceleration of the closure of these high quality nursing home, which is simply horrible for a—has horrible implications for access to care and quality of care for people who need nursing home care. So, we're prepared to work with you and—and certainly, you know, as Lorraine said, we believe more staffing is a good thing. It's just about the approach, and—and we do register our

objection to both the Resolution and the underlying legislation. Thank you.

CHAIRPERSON RIVERA: Thank you. I just have a question for Ms. Ryan. So, you said there are alternative ways to estab—establish safe staffing practices, but specifically what are they? What are your recommendations?

LORRAINE RYAN: Well, as I—I've listed all of the agreed upon approaches that NYSNA and the hospitals that have successfully negotiated and ratified contracts this year. There are other ways to support nursing, and we've brought these, you know, many of our hospitals already do this. Having room to our specialists, having a lift team so that's not just up to the nurse to move a debilitated patient from the bed to the chair where you ambulate. Having ICU trans—or, yeah, ICU transport supports so you're not pulling the RN off the floor to move a patient who's on oxygen and a cardiac monitor that's going for a test somewhere else in the institution. Admitting a discharge support. Never has it been more important to ensure a safe discharge of a patient back into a community, and to avoid a readmission both someone who's got a chronic illness.

So, the time that it takes for social work to spend with that patient and family. We had Care Act they passed in New York in 2016 that requires hospitals to spend time with the caregiver in the home not always the son and daughter who might be at work, but the neighbor, the friend who's going to actually help that patient take their medications, and going through the medication regime—regime. What are they for, what are likely side effects, what kind of food and when should you eat food before and after medication. There—I could go on and on about the types of support that we think could be more helpful. Clinical pharmacists on oncology units so it's not up to the nurse to be concerned about the side effects, and understanding when the best time to give a patient a certain med that is steering side effects, whether it's nausea, vomiting or the inability to eat. So, there are many other ways that we need to spend money on but, are much more—well, would be a much more efficient and holistic way and—and not really—and not increase for fragmentation of care of care to provide the best care possible for patients.

CHAIRPERSON RIVERA: And to Ms. Pavaris and Scott. Can you tell me if that's enough?

SCOTT AMRHEIN: Yes, sir, yeah. If I can struggle and everybody does. It's Amrhein so--

CHAIRPERSON RIVERA: Amrhein?

SCOTT AMRHEIN: So, yes.

CHAIRPERSON RIVERA: So, you're looking for an exclusion to—for nursing homes as similar to what is in California legislation?

SCOTT AMRHEIN: I mean, you know, we—we think for all the reasons both Lorraine mentioned that it's really inappropriate whether it's for hospitals or nursing homes. What we think and, you know, you said it in your testimony we need to go give the a chance to the federal standard that was just created. It's only really just been put into effect in the last coupled of years. It requires nursing homes to define, you know, facilities specific, staffing plans that are calibrated to the acuity of their patients, and then to be assessed and—and certainly on those, and then to be held accountable for those, and we think that's a very powerful model, and we think it needs an opportunity to prove itself.

CHAIRPERSON RIVERA: Well, thank you. Thank you for your testimony today. Appreciate you

for being here for waiting. You get almost as much credit as the last panel who I want to thank for waiting to testify. I—I really do appreciate you all hanging tough for the last 2-1/2 hours. Jill Furillo from NYSNA, Mark Hanning if you're here, Metro New York. I didn't see Mark.

FEMALE SPEAKER: [off mic] He's here.

CHAIRPERSON RIVERA: Oh, okay. Mario Henry. Great. Kevin Collins, Sheldon Fein, Muffazua Raman (sp?) and Anthony Feliciano. [pause] Okay, thank you. [background comments/pause]

FEMALE SPEAKER: Anthony is—

CHAIRPERSON RIVERA: [interposing] He's gone?

FEMALE SPEAKER: Yes.

CHAIRPERSON RIVERA: Okay, I saw Mario, I saw Mark, I see Kevin, Sheldon.

FEMALE SPEAKER: I think Shelly had to leave.

CHAIRPERSON RIVERA: Shelly had to leave. Okay, well I'm sorry, and you're Mr. Rahman?

MUFFAZUA RAHMAN: Yes.

CHAIRPERSON RIVERA: And there's—I sand Anthony didn't I? Okay, I guess I got everyone, right? Alright, take it away.

MAHFURUR RAHMAN: [off mic] We will. Hello, oh. [on mic] [background comments] It's working, right. Right? Okay, good afternoon Honorable Chair Woman. My name is Mahfurur Rahman, and I'm the Executive Vice Secretary on Community Board 11 as well as the Vice Chair on the Human Services Committee. I'm here today representing Community Board 11 in regards to safe nurse patient ratios at Mount Sinai Hospital. So more or less on February 19, the Board took the position in regards to and taking to strike, and I'm just going to for the testimony read aloud what we've resolved on. Whereas, Community Board 11 is aware that there is a danger of impeding strike of the nurses at Mount Sinai Hospitals, which we understood would have a devastating impact on our community. Whereas, in the current contract negotiations between Mount Sinai and New York State Nurse Association, the two sides have not agreed on staff levels per unit particularly the number of registered nurses per patient. Where it has been reported by the representatives of the

nurses that their hospital has not complied with the previous contract guidelines. Whereas, moreover, academic and specialty nurse associations recommend nurse-patient times safely shows for example one registered nurse per three patients in emergency rooms, if considered a safely show (sic)and; Whereas, the new registered nurses at Mount Sinai Hospitals report ratios of 1 registered nurse to seven patients in the emergency room at differential that it confirms is alarming. Now, therefore, let it be resolved that Community Board 11 urges the New York State Nurses Association and Mount Sinai to negotiate in good faith in order to agree in their collective bargaining agreements upon safe registered nurse to patient ratios in each unit of Mount Sinai [bell] that resolved in better patient outcomes, and for both Mount Sinai and the union to make every effort to prevent this strike, and to do so much on those. (sic)

CHAIRPERSON RIVERA: Thank you. I served on my community board, too. [laughter]

MARK HANNAH: [coughs] Good afternoon, Chair Rivera. Thanks for hold this hearing today. My name is Mark Hannah. I'm Director of Metro New

York Healthcare for All. We're a citywide coalition of community groups and labor unions that advocates for universal healthcare and strategic steps toward that goal. New York State Nurses Association is—has been—long been a member of our Coalition's Steering Committee. We strongly support the establishment of staffing ratios for nurses in all hospitals and nursing homes through legislation, regulation and/or negotiated contracts between employers and their unions especially in our city's public hospital system and in other inpatient facilities in our city with whom the city government made contracts. We're pleased to learn that our Council is poised to support the Safe Staffing for Quality Care Act now before the New York State Legislature, and we support the council's adoption of Resolution 396 that was introduced—introduced by Council Member Cabrera. Our Coalition's core mission is having city, state and federal government either individually or collectively assure healthcare for all New Yorkers ideally through a universal public program for all state residents. However, even once comprehensive insurance coverage is in place, that does not necessarily mean that needed services are available

in the community nor that quality services are provided. One of the key factors in assuring timely access to quality hospital care and appropriate levels is appropriate levels of clinical staff, appropriate to a given department. Proper staffing also saves money for our overall healthcare systems and prevents additional and unnecessary morbidity and mortality for individual patients, additional stress and burdens on informal family caregivers and protects the public's health. While the oversight of our city's hospitals and nursing homes primarily lies with state government [bell] local government also has a leadership role to play. It can set proper standards for our city's public hospitals, and use them as prime example that the standards proposed by the Safe Staffing for Quality Care Act are indeed feasible, economic and effective. Further, it can require all healthcare facilities that contracts move to adhere to the bill's standards since not all New Yorkers receive services solely within our public hospital system. Thanks for the opportunity to comment, and we thank you for your leadership on the Council, and the committee for taking up this issue,

and I have written copies, and actually that it is that.

MARIO C. HENRY: Can I move over there?

MARK HANNAH: Okay.

MARIO C. HENRY: Can you hear me? Alright, okay. Chairman Rivera, members of the Committee on Hospital, Council Members, my name is Mario C. Henry. I'm a senior citizen, a member of New York State Senior Action Council, and for these reasons we're in support of amending Resolution 396. Senior citizens by their very nature, their age spend more time in medical facilities. Seniors consume two-thirds of all healthcare services providing making them statistically more vulnerable to the adverse effects of not having proper care in hospitals and nursing homes. Seniors run greater risk for more frequent and more severe adverse reactions to medications. Seniors run greater risk of contracting pneumonia. Seniors are at greater risk of getting pressure sores. Seniors are at greater, they are at a greater risk of falls and fractured bones. They more than any other age group need adequate numbers of nurses present to monitor their conditions and elect physician's assistants and

doctors to call in a timely fashion, the periodic visit by a doctor. A physician's assistant will not be enough to assure a timely response to an unanticipated change in a medical condition. By the time a doctor's physician's assistant sees the problem, the senior might very well be dead. Nurses are the first line of defense for patients, and sometimes the difference between life and death. Senior citizens have a right to know that in their so-called golden years they will receive proper care in a timely manner. Seniors have a right to know that when they are most vulnerable, they will not be neglected. The New York State Nurse's Association has shown based on publicly available documents that the additional cost of adequately staffing medical facilities is not prohibitive. The cost of adequately staffing would be only 1-1/4% of the total revenues of the New York State Hospitals, and only 6-1/4% of the money hospitals spend on non-patient care. I do not think citizens when they—senior citizens when they are—are most vulnerable [bell]—I do not think it's too much to ask to avoid neglecting our senior citizens when they are most vulnerable. That concludes my statement. [applause]

KEVIN COLLINS: Good afternoon. I'm Kevin Collins the Executive Director of Doctor's Council SEIU. Thank you to Chair—Council Member Rivera and all the members of the committee for the opportunity to testify here today. We represent thousands of doctors in the metropolitan area including in every New York City Health and Hospitals facility, the Department of Health, Correctional facilities and other city agencies. As a healthcare unit of physicians we support the Amended Resolution No. 396 endorsing state enactment of the Safe Staffing for Quality Care Act. Quite simply, doctor's care for patients for a number of reasons including to make them better through treating an illness and to manage a chronic condition. The best way to do this is with the proper staffing of all the members of the Patient Care Team especially nurses. Doctor follow the adage of Do no harm. The best way to avoid this is by not being short staffed. Our doctors see every day how nursing care is critical to the delivery of quality and safe patient care. Having enough nurses to provide that care is vital. Safe staffing saves lives. The Journal of the American Medical Association, JAMA, published

research that estimated five additional deaths per 1,000 patients at current hospitals routinely staffed with 1 to 8 ratio as compared to those who are 1 to 4 ratio, and that the odds of a patient's death increased by 7% for each additional patient that the nurse must care for at one time. Safe Staffing improves patient outcomes. According to the U.S. Department of Health and Human Services the inaccuracy of nurses an other direct care staffing goals leads to poor patient outcomes and workplace injury rates. According to another report published by Health Services Research. Nursing homes which have safe staffing ratios have better quality of care in the facilities and improve functional status of their residents. If we put the patient at the center of making our healthcare policy decisions, then surely we would put safe staffing of nurses at the top of any list to make sure that patients receive the best possible care, and that the patient experience a satisfaction as is best as can be. That should be our guiding light, putting the patient at the center of our decisions. [bell] With a properly staffed department in the division, we can have better patient outcomes, reduce unnecessary re-

admissions, less nursing turnover and burnout, lower patient stay and reduce legal costs. It's been found that hospitals with lower nursing staffing levels have higher incidents and rates of pneumonia, and other medical aspects as well. We also agree with calling upon the city of New York to consider pursuing similar legislation with the Health and Hospitals. I will point out this that we are about to enter into bargaining. So, we've done a lot of conversations with doctors throughout the city hospital system as well as surveys, and ask what would you like to see to help improve patient care. What are the barriers to good care? And over and over and over again the response comes back: We want to have more staff and especially more staffing of nurses, and that's the doctors' perspective that having more staffing of nurses will lead to better patient care outcomes, and a base—better patient experience both for the patient and for the family members. The rest of my comments you can read in the testimony that I've submitted and I thank you for your time.

JILL FURILLO: Good afternoon. I'm Jill Furillo. I'm the Executive Director of New York

State Nurses Association, and I'm here primarily to testify to the actual facts of what our Safe Staffing has done in California, as well as what the actual situation is here in New York, and I'm reading the testimony provided by the Greater New York Hospital Association where it says that forced nurse staffing ratios would crowd out other essential members of the healthcare team, et cetera, et cetera, et cetera. I'm not going to quote the whole paragraph only to say that that just is not true and did not happen in California. All of the studies show that that there has been an actual increase in the total numbers of people who are non-RNs who are caring for patients in California hospitals right now. Those are the facts and the studies show that. The—the issue about forced nurse staffing ratios would cut—I'm sorry—they would cause New York hospitals and nursing homes billions and billions of dollars. These same things were said in California and much of the testimony provided in a lead-up to the pass—the successful passage of the Safe Staffing Act in California and, in fact, hospitals made more money in the ten years following the actual implementation of the nurse staffing ratios than they made into the prior ten

years to the passage of that legislation, the implementation of t hat legislation. They made billions and billions of dollars. There are two people that have been in this room today that actually were on the ground when staffing ratios were implemented in California. One is not here right now, but I do know him well. His name is Dr. Mitchell Katz. He's the CEO of the H&H system. I was there as well. I was Director of Government relations for the California Nurse's Association, and both of us experienced when the—when the California ratios were implemented. We saw that number one, safe staffing ratios saved lives. There were better outcomes for all patients involved. All of the indicators that you would look at have been studied and studied and studied [bell] and have shown that patients do better with the implementation of these ratios. The second thing that we found again, as I will state again, is that hospitals do better. As a matter of fact, under Dr. Katz's leadership in the public health systems in California both in San Francisco and in Los Angeles, they maximized what they could do with these ratios, and as a result those two systems brought in more dollars throughout

the years when Dr. Katz was there, and one of the ways that they were able to bring in those dollars had to do with the staffing improvements. People stayed in that system. They were given the option under Obamacare, if you recall, to perhaps move out of the system, but people I the public system didn't leave. They stayed, and they received excellent care in the County Health Department as a result of Safe Staffing implemented in 2004 in California. So, it brought the revenues necessary to save those public health systems that were suffering some of the very same ills that we're suffering right now in in this state, which brings us to another mess, which is that the nursing homes that the—that the nursing homes were excluded in legislation in California. No, the nursing homes act--actually were not excluded. The nursing homes passed legislation the year-the year after the legislation was passed for hospitals, and did implement a system of safe staffing in the nursing homes. So, that—just—just to be factual, they did do these reforms. It was based on analysis for patient care model, which is very similar to—and it is a methodology that's similar to a ratio system. The issue of—of the problems about the ED wait times,

the access to care these kind of things, that's already happening in the hospitals. You can ask any of these nurses right now about what is going in the emergency rooms about the ED wait times. You can speak to the nurses about what is happening on the floor in our H&H hospitals. They did testify the other day when we opened up negotiations, and the reality is, is that the things that the Greater New York Hospital Association is talking about that these will happen. No, no, it's not that they will happen, it's that they're already happening, and the implementation of Safe Staffing is the cure for that. The Greater New York Hospital--

CHAIRPERSON RIVERA: [interposing] We did have—we do have a number of nurses testify--

JILL FURILLO: Exactly.

CHAIRPERSON RIVERA: --and—and they were personal, and they included a number of stories from many of the nurses who are in different departments as well. It was very diverse. So, I want to thank you for—for organizing. LEADS (sic) obviously organizes of course and to the advocates as well. I just want to ask you to—to wrap. If there was a last part.

JILL FURILLO: Yes, yes. I just was going to finish and say that the Greater New York Hospital Association and all of these associations that don't want regulations are—they're just missing the point, which is that a highly regulated environment is absolutely necessary when you are talking about patients' lives. We are talking about safety regulations. I mean we wouldn't say that to the airline industry. We wouldn't say that to any other industry where patients—where people's lives are in the hands of—of a workforce, and the—the fact of the matter is that the private hospitals have not done due diligence to supporting this system our H&H system, and as a matter of fact, we should be looking at some of the recommendations that have come out the recent paper that was issued by two authors who studied the H&H system that we actually need more regulations and we need these hospital systems to actually pay their fair share and that they should be supporting our public health system in a better way so that we can have the safe staffing. It's absolutely essential in this legislation. Thank you.

CHAIRPERSON RIVERA: Thank you. [applause] Thank you everyone. I—I want to just

thank everyone from the Community Board and—and long-time advocates for universal healthcare and, of course to the Doctors Council. Thank you for bring a doctor's perspective. I think that's so important because the nurses are there to take care of the patients first and foremost , but they are the front line to support the doctors and, of course, making sure that we're all taken care of throughout every stage of our life. So, I want to thank you. I know that we have a lot of work to do, and I hope that we can do it together. I know that—I hope you all consider me an ally, and for everyone here that testified as to [coughs] alternatives or to possible remedies or ways around this legislation, I think that by the experiences that were shared today, the stories that you heard, standardization does seem to be a common them, but when you have someone who has 15 patients at a time, that is a disservice to the people of New York City, and that should be in no way standard in any part of this country. So, I want to thank everyone. You are incredible. Thank you for your time. I don't see any more members of the public who wish to testify, and with that, I'm going

to adjourn this hearing. Thank you. [gavel]

[applause]

C E R T I F I C A T E

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

Date July 3, 2019