CITY COUNCIL
CITY OF NEW YORK

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TRANSCRIPT OF THE MINUTES

Of the

COMMITTEE ON HOSPITALS

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HELD AT: REMOTE HEARING (VIRTUAL ROOM 2)

B E F O R E: Carlina Rivera,
Chairperson

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A P P E A R A N C E S

Dr. Eric Wei
Senior Vice President and Chief Quality Officer at New York City Health & Hospitals

Dr. Andrew B. Wallach
Ambulatory Care Chief of New York City Health & Hospitals

Dr. Shaw Natsui
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Marie Mongeon
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Anthony Feliciano
Director of the Commission on the Public's Health System

Greg Mihailovich
American Heart Association

Michael Davoli
American Cancer Society

Judith Cutchin
President of the New York City Health & Hospitals Executive Council

SERGEANT BIONDO: Thank you.

SERGEANT DAUTAJ: Pod recording is good.

SERGEANT BIONDO: Thank you. Sergeant Sadowsky just waiting on confirmation of the live stream. Just give us one second.

SERGEANT SADOWSKY: Roger that.

SERGEANT BIONDO: Okay, Sergeant Sadowsky.

SERGEANT SADOWSKY: Good morning and welcome to today's remote New York City Council hearing of the Committee on Hospitals.

At this time, would all panelists please turn on their video. To minimize disruption, please turn electronic devices on vibrate or silent mode. If you wish to submit testimony, you may do so at testimony@council.nyc.gov. Once again that's testimony@council.nyc.gov.

Thank you for your cooperation. We are ready to begin.

CHAIRPERSON RIVERA: [GAVEL] Thank you for joining our virtual hearing today on this very, very important issue. I want to thank everyone who has made this happen today. I know it was a very long exciting and hot day yesterday. So, thank you for

being here bright and early and I appreciate everyone.

So, again, I just want to thank the staff and the team and all the advocates who are here and I'd like to also acknowledge that Council Member Maisel is here with us today.

So, good morning, my name is Carlina Rivera and I am the Chair of the Committee on Hospitals. I'd like to start by thanking my colleagues for joining me today as well as all of the advocates and others who have joined us for this remote hearing.

New York City is in the process of reopening after a devastating wave of coronavirus case which took the lives of thousands of New Yorkers. In late March and early April, the situation and the city's hospitals was dire. As the city was experiencing an increase of around 1,600 new hospitalizations per day. To avoid straining hospitals anymore than they needed to be, much care was deferred.

All elective surgeries were canceled and many services such as preventative care and primary care were delayed. Patients were scared to seek care and risk catching COVID-19 and many facilities were closed or limited in the services they could provide.

As we ease restrictions and reopen the economy, this includes the reopening of more and more hospital care. Today, we are focusing on what the reopening process looks like for our city's hospitals.

We are interested in learning about what services are rolling out and what safety measures have been put in place as more and more people return to hospitals for much needed medical care. As people return to hospitals for surgeries and other procedures, I am curious to know how hospitals are still managing to care for those with COVID-19 and how are ensuring the safety and well-being if every patient.

We are also interested in how hospitals are informing patients about the availability of care and how to ensure that the message is reaching all communities, particularly those that experience higher rates of chronic conditions, cancer, and other medical needs as well as those who do not primarily speak English.

The amount of healthcare that was deferred should be of foremost concern for all of us. According to a recent poll by the Kaiser Family Foundation, nearly half of adults say they or someone in their household

postponed or skipped medical care due to the coronavirus outbreak. With most expecting to get care in the next three months as restrictions ease, according to research by the Commonwealth fund, the number of visits the ambulatory practices declined nearly 60 percent by early April. And although it has sense rebounded slightly, the number of visits is still roughly one-third lower of what was seen before the pandemic.

Access to vaccinations, dental care, preventive care, and cancer related care, as well as emergency care unrelated to COVID, have all been highlighted as particularly concerning. According to DOHMH, from March 23rd to May 9th, the number of vaccine doses administered to children dropped 63 percent compared with the same time last year and by 91 percent for children older than two.

The pandemic has had a profound impact on individuals diagnosed with cancer with reports of people delaying or deferring cancer related care.

According to a survey by the American Cancer Society, 79 percent of patients in active treatment for cancer reported a delay in their healthcare. Delays were also common among patients who are not

currently in active treatment. With 78 percent of such patients reporting their healthcare has been delayed. Overall, one-fifth of all cancer patients and survivors surveyed reported concern that their cancer could be growing or returning due to their challenges in obtaining healthcare.

There have also been reports of a decline in admissions for heart attacks and strokes. It is clear that people who need medical care have not always been able to get it. So, this begs a question, how are we as a city ensuring that people are safely returning to care and how are we addressing the potential setbacks New Yorkers will experience after delaying care for months.

All of this occurring while we simultaneously work to avoid a second wave of cases. Hospitals must remain prepared. Even as they focus on reopening, hospitals must keep an eye on our indicators and remain at the ready to accept patients with COVID-19 symptoms if a second wave of cases materializes.

Today, I look forward to hearing about the precautions in place in the event that we do see an increase in the need for COVID related care, and I also look forward to future conversations with H&H

and others about how we are ensuring our budget reflects the needs of our city.

Thank you all again for being here today and I look forward to a robust discussion.

I will now turn it over to our Moderator to go over some procedural items.

MODERATOR: Good morning and thank you Chair Rivera. I am Emily Balkan, the Senior Policy Analyst to the Hospitals Committee of the New York City Council.

Before we begin testimony, I want to remind everyone that you will be on mute until you are called on to testify. After you are called on, you will be unmuted by the host. There maybe a few second delay once you are unmuted. I will call on panelists to testify, please listen for your name to be called. I will be periodically announcing who the next panelist will be.

We will be limiting Council Member questions to five minutes and this includes both questions and answers. Please note that we will not be allowing a second round of questions.

For public testimony, after the first panelists, individuals will be called up in a panel of two or

three. Council Members who have questions for a particular panelist should use the raise hand function in Zoom. You will be called on after everyone on that panel has completed their testimony.

For panelists, once your name is called, a member of our staff will unmute you and the Sergeant at Arms will give you the go ahead to begin after setting the timer.

All public testimony will be limited to three minutes. Please wait for the Sergeant to announce that you may begin before delivering your testimony. I will now call on the following members of the Administration to testify. Dr. Eric Wei the Senior Vice President and Chief Quality Officer at New York City Health & Hospitals. Dr. Andrew B. Wallach, the Ambulatory Care Chief of New York City Health & Hospitals and Dr. Shaw Natsui, the Director of Emergency Medicine Innovation for New York City Health & Hospitals. I will first read the oath, then I will call on each member here from the Administration individually to respond.

Do you affirm to tell the truth, the whole truth and nothing but the truth before this Committee and

to respond honestly to Council Member questions? Dr. Wei?

DR. ERIC WEI: Yes, I do.

MODERATOR: Dr. Wallach?

DR. ANDREW WALLACH: I do.

MODERATOR: And Dr. Natsui?

DR. SHAW NATSUI: I do.

MODERATOR: Great, thank you. So, Dr. Wei, you may begin when you are ready.

DR. ERIC WEI: Alright, thank you so much. So, good morning Chairperson Rivera and members of the Committee on Hospitals. I'm Dr. Eric Wei, Senior Vice President Chief Quality Officer for New York City Health & Hospitals.

I'm joined today by Dr. Andrew Wallack, our Chief Medical Officer for Ambulatory Care and Dr. Shaw Natsui our Director for Emergency Medicine Innovation at Health & Hospitals. It is a privilege and a pleasure to be able to testify twice in two weeks. So, it's great to see you Chairperson Rivera and the rest of the committee.

Thank you for the opportunity to testify about Health & Hospitals reopening plans. I think first and foremost, we never closed. We certainly didn't

feel like we were closed, we were very busy through the beginning of 2020 and we were fully cognizant in working diligently to make sure that our patients still receive the medications and the chronic disease management that they needed throughout the crisis in our emergency departments and hospitals and operating's remain open throughout the first wave.

It's been discussed today, how were increasing capacity to perform a higher number of scheduled medically necessary surgeries for existing patients. Our increasing the capacity of limited in person ambulatory care visits across the system, while continuing to build upon the success of our telemedicine apparatus. As well as how we are doing everything in our powers to keep patient staff and our communities safe when they seek emergency care in our emergency departments.

As well as continuing our test and trace functions on positive COVID-19 cases in order to limit spread of the virus. So, I just want to reiterate that New York City Health & Hospitals is open and more safe and we stand ready to deliver emergency primary specialty and perioperative care to New York City.

And as the city enters phases two and three of reopening, we're urging all New Yorkers to seek the care that they need and deserve and we stand ready.

Patients in need of in person appointments who are seeking emergency care will experience a new safer patient environment in this post-COVID pre-vaccine world. We are requiring all patients over the age of two and visitors to wear face masks and encourage use of gloves. You are also encouraged to do frequent hand hygiene while in our facilities. There is mandatory temperature and symptom checks for all patients and visitors. Those who screen positive are provided care as well as being part of the test and trace.

As prompt triage and isolation of any person with a fever, we have redesigned waiting rooms with floor decals. How the chairs are organized to encourage social distancing. There is a lot more plexiglass in this post-COVID world. Sneeze guards have been installed in all registration welcome areas and throughout our ambulatory and emergency departments.

Clear signs remind staff and patients of what the proper personal protective equipment for that area is

and we have reserved early morning appointments for elderly patients and those who are most vulnerable.

So, I'm going to move to discuss some of the preparations and changes in our inpatient areas. So, as our COVID-19 patient census has declined, New York City Health & Hospitals has entered a recovery and resilience phase. As of June 14th, in compliance with the New York State Department of Health's directive, surgical departments across our 11 hospitals have increased their capacity to perform all essential surgeries. With a prioritization of approximately 9,000 total cases that have been postponed secondary to the Governor's executive order.

For March 16th through June 14th, H&H only performed emergent, urgent, and otherwise essential surgical cases. The later to find that surgical cases that should not be postponed any longer. Examples, including surgery for cancer increasingly symptomatic patients.

So, during the time period that surgical cases were restricted, several processes were put in place to ensure the safety of our patient and staff. Systemwide PPE protocols were developed, a governance

structure was put in place at each facility to oversee the performance of scheduled procedures to ensure compliance with the governors executive order.

In preparation of reopening our operating rooms, a roadmap was developed to facilitate the performance of cases which had been postponed.

So, since June 14th, the perioperative leads at each facility have been working diligently to bring back the procedural areas including ambulatory surgery units and the post anesthesia care units which in March and April during the peak were being utilized as flex ICU spaces to care for all the critically ill COVID-19 patients. Every patient that is scheduled for surgery undergoes a COVID-19 test prior to the date of their scheduled surgery and ambulatory care. COVID-19 testing capacity is established provides same day access.

Specific operating rooms have been designated for patients who are COVID-19 positive and we're happy to announce that as of June 21st, we've hit close to 80 percent of the surgical productivity of what it was pre-COVID-19 and we are confident that we will hit 100 percent if not higher shortly.

In addition, we do have 44 percent ICU capacity and 41 percent medical surgical capacity in case a second COVID-19 surge.

Today is a very exciting day and I think a landmark for New York City Health & Hospitals as well as a city as we recover from that first surge. Today, all 11 of our hospitals will be allowing limited hospital visitation, one of the most heartbreaking aspects of the nature of COVID-19 pandemic was that to keep patients and to keep visitors and staff safe, we had to separate loved ones from patients due to the Governor's appropriate orders.

Coney Island Hospital of Jacobi Medical Center in North Central Bronx with three H&H Facilities that participated in a New York State Department of Health two week highlight on hospital visitation and all three were very successful and we're glad that we've taken the step towards more normalcy and allowing loved ones to be at patients bedside.

So, visits at each of the hospitals in accordance with the Governors stipulations, limited to one visitor at a time 18 years or older for no more than four hours a day. Patients in all departments of the

hospital will be allowed visitors. Visitors will be advised to perform meticulous hand hygiene, be provided, and trained on how to appropriately wear PPE. They will undergo symptom and temperature checks upon entering the hospital and we will be keeping an electronic log of all the visitors in case we do need to do tracing in the case of an outbreak.

I'm going to move to ambulatory care. So, Health & Hospitals Ambulatory Care Clinics are also busy transforming to this post COVID pre-vaccine world. We want to provide the safest environment possible. The reopening of 11 hospital based ambulatory care sites as well as 30 Gotham health community sites will be phased in the approached. In early June, the goal of our outpatient clinics was to have 20 percent in person visits while continuing to conduct tele-visits to reach the rest of the patients as well as for new patients.

We offer primary care in over 90 specialty care services. All patients now have the option to access their care from home if they feel safest there via phone or tablet when it is clinically safe to do so.

We were able to quickly scale up tele-medicine services and this is one of the big successes during

the peak. We went from only 500 billable virtual visits in a month, in the month prior to COVID-19 reaching New York City up to nearly 57,000 in the first three weeks, and we have done over 345,000 tele-visits through the middle of June.

Also, our electronic patient portal being all on the same electronic medical record epic My Chart, allows patients to save time on their next in person visit by signing all their forms and doing E-Check in. And so, this is another way to decrease the amount of time that patients spend in the waiting room or in our facilities by signing these forms and being ready for their visit as soon as they arrive.

We encourage all of our patients existing and new to sign up for My Chart as a way for you to manage your health 24/7 from home, request medication refills, message your care team and get responses from your provider.

We've also created something called fast check visits. So, not quite the same as drive through COVID-19 testing but that's the idea, we want you to spend as little time as possible being exposed in our facilities and decrease the amount of foot traffic, the amount of people in each space to allow social

distancing. And so, the idea is to have a safe way to have vitals checked, lab work done prior to your telehealth visit.

And even in the middle of a once in a century pandemic, our NYC Care team has been working very hard to make sure that this guaranteed healthcare initiative reaches the boroughs of Queens and Manhattan. We are still on track. This included hiring 26 new providers. We are providing new primary care appointments within two weeks and continuing to grow in the Bronx, Brooklyn, and Staten Island. To date, we have reached 22,705 New Yorkers enrolling in NYC Care.

I'm now going to transition to the emergency departments. So, this is where I work clinically. We've teamed up with our office facilities development supply chain, information technology in our ED COVID action team to work on in this post-COVID pre-vaccine H&H Emergency Department.

And so, we know that we didn't just hit pause and now we can pretend to go back to January or December pre-pandemic times. We know that we can't just say, we're going to see the same number of patients in our

emergency department but everybody just stay six feet apart. There is not enough space to do that.

And so, some of the things that we're doing is what the social distancing looked like in our emergency departments. How can we reach patients where they are with on demand telemedicine at home to reduce the number of people coming into the emergency department. And even when they do come into the emergency department after a medical screening examine, do they need to be seen in our physical plant of our emergency department or can they go to our urgent care or can they go to labor and delivery or to an outpatient clinic to have their minor complaint addressed.

We are also where we can't do social distancing leveraging physical barriers. So, once again, plexiglass plays a big role in this post-COVID pre-vaccine world. We have all of our patients and visitors where masks or face coverings. Our staff are always wearing N95's and eye protection to reduce the chance of infection and possible spread to patients and visitors.

We also are leveraging technology. So, even if you are in my emergency department, besides being in

the room to do the initial history and physical, including you know, the physical exam, if I just have one repeat question or if it's a non-clinical person, like a social worker who needs to ask questions, do they need to be within six feet of the patient or can we ask those questions via video conferencing?

And finally, I'm going to talk a little bit about our T2 Test and Trace. So, this is the biggest difference between January, February, March, and today is now that we have testing ability and we have tracing ability, we are in a much better position to be able to respond to any sort of outbreak, any sort of spread. Be able to test, to isolate patients and reduce the chance of having a similar peak like we did in March and April.

So, we currently have the capacity to do 30,000 tests a day. We will increase this to 50,000 tests a day by August. We are encouraging all New Yorkers to get tested. We offer free walk in testing at our hospitals, heath centers, pop up locations across all five boroughs. There are now more than 200 testing locations including those run by H&H. For anyone who tests positive, we now have over 3,000 contact tracers, more than 50 percent who come from the

hardest hit communities in New York City to contact cases, ask them who they have been in close contact with. To date, we've been able to hit a remarkable 97 percent of people who tested positive for COVID-19 we've been able to reach. 74 percent have provided close contacts and since then, we've reached 650 of those contacts who are actually symptomatic and likely contagious at the time. Being able to isolate folks at home as well as in our hotels and our latest modeling shows that prevented a possible 2,000 new cases in COVID-19.

So, while we're excited that today, we're allowing visitors back to our hospital. We're starting to allow in person ambulatory visits. Our emergency departments are open, they are safe. We've taken all precautions to keep patients safe when they come to seek emergency care. We know a lot of work still needs to be done. It does make us nervous about potential public health crisis on top of the COVID-19 crisis of patients being too fearful to seek care. And so, I stand ready when I'm working in the emergency department. Our system our doctors, nurses, healthcare workers stood ready to receive COVID-19 patients and we continue to stand ready to

see anyone regardless of ability to pay or any other factors.

Thank you for the opportunity to testify this morning and we look forward to answering your questions.

CHAIRPERSON RIVERA: Thank you so much and I want to acknowledge we have been joined by Council Members Moya and Levine as well. So, thank you so much for your testimony and absolutely you were providing care throughout the pandemic however, a lot of those services were limited for a number of reasons and I realize how many patients your staff at Health and Hospitals saw. I mean, you know, the 207,000 cases in New York City, 17,000 and more deaths and fatalities, this proportionately affecting Black and Brown communities and I know that many of your hospitals that you even mention Coney Island Jacobi, Lincoln, Metropolitan, Woodhall, they are all in this community, so thanks again as always to you and your staff for all of the work.

So, how much have non-COVID-19 usage rates for emergency departments declined since the start of the pandemic?

DR. ERIC WEI: Yeah, so our data and analytics teams were trying to pull these numbers as quickly as possible. So, I'm actually going to turn it over to Dr. Natsui who can share kind of what it looks like from the CDC on a national scale as well as what H&H has seen. So, Shaw?

DR. SHAW NATSUI: Great, thank you Dr. Wei and thank you Chair Rivera for the question. Good morning everyone. So, as was alluded to earlier this morning, across the country, we know that ED volumes and visits have declined since the pandemic. One of the earlier CDC reports had described a 42 percent decrease in ED volumes in the early parts of the pandemic across the country in aggregate.

When we look at our Health & Hospital side, we similarly saw and have seen a decline in ED volumes. We have seen since around January where we had about 96,000 ED visits decline through particularly in March, especially April and May where we hit a low in April 33,000 visits and starting to see a slight return in that to 38,000 in May. As a point of comparison, these volumes compared to 2019, are about 60 percent lower in April and May compared to where we were a year ago.

To illustrate who these patients are that are different or not presenting. Right now, it's mostly in the lower acuity ranges, so ESI 4's, 5's and some 3's represent the vast majority of the ED volume decline. And to clarify, this is for all ED visits which includes both COVID and non-COVID concerns.

When we try to dig a little bit deeper into our data and looking at trying to isolate just the non-COVID patients, so kind of the comparison group to historically who we would normally expect to see. We do understand and see that there is a more pronounced decline and those volumes closer to a 65 to 70 percent range when we look at those changes.

So, overall, definitely seeing a similar phenomenon at H&H as seeing across the country in this regard.

DR. ERIC WEI: And just to clarify ESI stands for Emergency Severity Index, which is a triage kind of denotation of how many resources a patient coming into the emergency department might need.

And so, ESI 4'S and 5's, think of those as your fast track or your urgent care lowest acuity patients. ESI 1's and 2's are your significant traumas or cardiac arrests coming in. And so, it

definitely is the lowest acuity. I will say that each week that I work in the emergency department and speaking with our emergency department Chiefs, each week there is more and more patients coming back and we had an ED counsel call yesterday where they are feeling like it's somewhere between 45 and 60 percent of pre-COVID volumes.

CHAIRPERSON RIVERA: Great, thank you and I think you know, that was one of the reasons we've spoken a lot, myself and members of your team, on how we can really work on messaging and reaching folks about going back to the hospital which I tell people all the time that's it is very, very safe.

And so, I think just this hearing is to really highlight that there is a plan. You are implementing it as quickly as possible and so, those nonessential procedures that are offered at H&H hospitals across the city, were suspended by the Governor's Executive Order to expand the hospital capacity during the pandemic. Have those services begun picking up again? I know you mentioned a few of them in your testimony, but were some cancer related surgeries and procedures suspended and how are you ensuring that

important previously scheduled procedures are rescheduled in a timely fashion?

DR. ERIC WEI: Yeah, thank you for that question Chairperson. So, as I had mentioned, we had a total backlog of about 9,000 procedures and so, working very closely with each of the directors of perioperative services across the system along with our system leadership and our data analytic teams. We were able to leverage technology to filter for certain diagnosis and indications for surgery and cancer was at the very top of that and being able to outreach to those patients, get them in for preop testing, get them in for their COVID-19 test and get them scheduled for the surgery.

And so, going through all 9,000, which ones at each of the 11 facilities and you know, which one is first, which one is 10, which one is 100. Being able to create these lists and having all of our resources and perioperative services getting those patients as quickly as possible into the operating room for their procedure that they needed. And so, as I mentioned, we are at 80 percent of our pre-COVID volume as of 6/21. We also took all of these — took it as an opportunity to reset and really think about just

because this is the way that we have always done things, is this the most efficient way? We learned a lot of lessons about efficiency and throughput through the COVID-19 surge. So, we believe we can actually do even better in this post COVID world in terms of starting surgeries on time, turning around cases, how we block off schedules, how do we schedule you know, if it's a three month wait at one facility and there is a two week wait at a different facility for the same surgery, how can we get patients to that separate facility and work as a system. And so, really taking this as an opportunity to do even better than we were doing pre-pandemic.

CHAIRPERSON RIVERA: And the technology that you are mentioning in terms of, I know that telehealth has really, really ramped up. You mentioned 57,000 telehealth visits in the first three weeks I believe of the pandemic and then the number that I also heard was 345,000 through mid-June.

So, I guess that answers my question about how many you have provided since March. It's in the hundreds of thousands, is that correct?

DR. ERIC WEI: Right, and I'm going to allow Dr. Wallach to address this piece of how we have stayed connected with our patients even if they are at home.

DR. ANDREW WALLACH: Great, thank you Dr. Wei and good morning Chair Rivera.

Indeed, when we look at our tele-visit volume, we are averaging approximately 28,000 visits by telemedicine per week to provide access to our patients at home. Interestingly enough, when we look specifically at our primary care patients and our behavioral health patients, our overall visit volume pre-COVID to compared to today, has remained unchanged. And this is because of the large number of tele-visits and outreach that we've done to our patients.

So, throughout the pandemic, we have been able to maintain access for our patients. They have been able to get their medications renewed. We are relying on home monitoring for example, blood pressures taken at home by automated machines as well as glucometer for our patients with diabetes and we've been able to continue to provide care, including adjusting medications, doses and having

them have their questions answered by their healthcare team.

CHAIRPERSON RIVERA: How do patients access prescriptions or the medical devices, like blood pressures cuffs, when they are prescribed through telehealth services?

DR. ANDREW WALLACH: So, pre-COVID, we have actually made a big push to move towards home monitoring. So, many of our patients with hypertension for example, already have these devices in their homes. If patients have insurance, it is often covered and so, we can send an electronic prescription to their local pharmacy for them to be able to retrieve those devices, as I said including the automated home blood pressure cuffs as well as the glucometers.

So, many of our patients already had it. I am a primary care physician. I have been seeing patients throughout the pandemic and I have to say it was really nice to be able to have that data when I was having conversations with my patients to be able to continue to make adjustments to their medications.

CHAIRPERSON RIVERA: Are the patients having any issues accessing technology for example, video versus

auto visits. I know there is for me personally, I think the estimate is about 29 percent of New York City households don't have access to broadband internet and so, while I think this is a citywide issue that I will certainly be working on, how does that effect some of your patients?

DR. ANDREW WALLACH: Yeah, absolutely. That's a really terrific question Chair Rivera. The vast majority of our telemedicine visits to date at New York City Health & Hospitals have been by telephone. Pretty much every patient has access to a telephone and that's one of the things we vow to be very important as far as health equity to make sure that these services were available to all of our patients.

As we are pivoting now further along, we are switching to more video capability. There was some technical issues that we had to stand up on our end. We have been very successful in being able to integrate the video visits directly into our electronic medical record, Epic. And so, we will continue to offer both to patients depending on their preference.

Now, that said, for folks who want to do video visits, we are setting up actually a helpline for our

patients, so if they do have any technical issues with the assistance of the helpline, the should be able to work through those.

I will also tell you anecdotally, for my practice, particularly some of my older patients who perhaps I had to buy out that maybe they did not use technology as well or as often as some of our younger patients. I have been pleasantly surprised that many of my older patients do have smart phones and if they are not able to fully use them themselves, often with the assistance of family members who are there helping them, I have been able to successfully connect with them.

So, it's been really a wonderful experience in making sure that that's been available to them as well.

CHAIRPERSON RIVERA: And I know many of these factors are out of your control and from what I understand there are people advocating to the state level to fix those reimbursement rates between audio verse visual. Which I understand is not a reimbursement.

Although reimbursement rates have gotten better for telehealth services, any suggestions on how they

could be improved? I mentioned the audio visual component but if there is anything of course for us to be able to advocate for on your behalf, I always you know, welcome those suggestions.

DR. ANDREW WALLACH: Yeah, well, thank you very much for that comment because as you just mentioned, the Governor has grind into law the statute that provides for audio only communications as an acceptable form of telehealth. It is only to be reimbursed by Medicaid if approved by the Commissioner of Health, contingent on federal financing participation. However, it is not covered for Medicare patients. So, that is still an ongoing issue.

And then also to your point that the telephonic tele-visit payment is significantly less than the video payment and it would be nice to see more parity in those reimbursement rates between those two different modes of telemedicine.

So, thank you for your advocacy on that.

CHAIRPERSON RIVERA: Of course, and you know, there is many things that you cannot get over the internet which includes vaccinations. So, I wanted to ask about some of the primary care issues in the

hospitals. From what I mentioned in my opening testimony, there has been a decline in the number of childhood vaccinations. How are you all addressing that issue?

DR. ANDREW WALLACH: Yeah, so very early on in the pandemic, this is something that we discussed with our pediatric leadership throughout the enterprise and realize this is at the utmost importance of not interrupting the vaccine schedule of our pediatric patients.

So, a couple of things that we were able to do successfully throughout the pandemic was first and foremost, that we maintained our in person visits for vaccination for pediatric patients throughout. We had very strong infection control practices and created something that we call clean lane. That basically means that we had a fast track registration and then right after that, the patient, the pediatric child, was brought back to a clean exam room for a Well visit, was given their vaccine and then was discharged directly home. So, that their time onsite was very minimal and encouraged them to come and get their vaccines.

In addition, we acknowledged especially during the peak of the pandemic, that many families were concerned about physically coming to a hospital based practice. Especially with the large numbers of COVID patients that we had hospitalized on our inpatient units and our ICU's. What we did, we took advantage of the fact that we are truly an enterprise at New York City Health & Hospitals and we opened up all of our community based practices as vaccine centers for our pediatric populations. So, we did outreach calls to our patients who were due for vaccines and said if you are not comfortable coming to the hospital based practice, you can go to one of our neighborhood community health centers where you live. And that was really important for making sure that our patients felt safe.

As I said, a large part of this was done on being proactive and generating lists from our electronic medical record as who was due and then doing reach out to them.

I can tell you the metric that we used for our pediatric population to understand how well we are doing with our vaccine is something called the up to date measure. Meaning that they have had all of the

vaccines based on their age and I can tell you that for our five month old's, we were down approximately 15 percent compared to where we were a year ago. We did much better for the higher age range. So, children between the ages of 7 months and 15 months, we were only down approximately 5 percent.

So, all that to say, all of these outreach efforts and making vaccines available at our various sites, we were relatively well able to maintain vaccine schedules for our patients.

DR. ERIC WEI: And Chair Rivera if I may add to that. So, I had this same discussion at home. I think I mentioned on our last testimony that my son was born at Bellevue in early February and so, right in May he was due for his three month shots. I was still isolated, you know, working emergency department shifts, going in all the hot zones in the hottest system in the EPI center from my wife and three kids. And so, my wife and I were having these discussions and the same anxieties. Is it safe to bring him into Gouverneur where we get our pediatrics care to get his three month Well visit as well as the vaccines? And so, I remember having conversations with his pediatrician who answered all of our

questions and laid all of our anxieties and fears and described this fast lane approach. Where you come in, you don't sit in the waiting room. You get registered and you get brought right back to a portion of the clinic that is dedicated to Well child exams and vaccines and a minimum number of staff come into the room. We saw his pediatrician, we got his shots, we were in and out and it's the same process that's available to all of our patients, not just you know, myself.

And so, I 100 percent understand the anxieties and the fears because we were having those same conversations in my house.

CHAIRPERSON RIVERA: So, are vaccinations being brought into the new — actually, let me ask you about the languages about the outreach because I was in — I had a very, very positive experience at Queen's Hospital last Saturday. I went to go get a COVID diagnostic test and I had a very brief visit there. Of course, I don't want to bother you all in the facility themselves during this very kind of challenging time but they mentioned of course like that hospital like Elmhurst, which I know Council Member Moya is a very strong champion of. That they

have over 100 languages spoken inside of this facility. So, in what languages has some of the outreach occurred? Do you have any idea? I realize that you use an interpreter service for the hotline that you typically had to help patients who speak a language other than English but how —in what languages has outreach occurred recently?

DR. ANDREW WALLACH: Yeah, so I can start with that. Certainly, on the ambulatory side, we have begun a campaign called, We Are Here for You. With the central method being that we are open and we are safe and we need you to continue receiving your care. We have spent over 300,000 emails out to folks, patients of our who have email addresses on file. We also are doing robocalls to remind people of in person appointments. Those are currently in English and Spanish and we are rapidly expanding to include additional languages.

In addition, we have created an FAQ fact sheet about COVID as well as about reopening of ambulatory care and I am happy to report that that is available in 13 languages our top languages.

As you mentioned, when patients are physically on site or whether we're doing a tele-medicine visit, we

do have the use of our interpreter service telephone which are really very helpful in being able to communicate effectively in the patients native language if there is discordance with the providers language.

CHAIRPERSON RIVERA: And how is pediatric care, how is it different when it comes to telehealth?

DR. ANDREW WALLACH: Yeah, so that's a great question. Depending on the age of the child right, often times just like an in person visit, much of the conversation with the pediatric patient is with the parent or guardian who is with that child.

So, again, it depends on the age. Certainly, the younger children, it's more of a conversation and discussion with the family or the guardian for that child. For older pediatric patients including adolescents, they are able to communicate directly and have that encounter.

CHAIRPERSON RIVERA: Thank you. So, you mentioned the visitation starting I guess it's today, right. That was kind of big announcement and on May 4th, I had sent — I wrote a letter along with the strong majority of my colleagues who signed on asking for hospitals to establish a compassionate helper

program that safely provides connections between family members and patients.

I realize that the program now is a little bit different but tell me the difference kind of between establishing a program like that. The two week pilot that was implemented at Coney Island, Jacobi, and NCB and kind of what you are doing now and how you are making sure that families do stay connected.

DR. ERIC WEI: Yeah, so, thank you so much Chairperson for that question and for your advocacy. As I had mentioned in the testimony, this was one of the most heartbreaking things for us to watch, putting ourselves in our patients and their families shoes. Imagine dropping off a loved one at the door at the emergency department and not be able to accompany them in and then they are being admitted to the ICU and you are you know, waiting for that once daily phone call from the provider team for updates.

And so, a lot of work went into our Connecting Families Initiative. And so, a lot of our repurposed staff from our ambulatory care teams actually moved in to our in patient areas, not only did they help out with the clinical care, they helped out a lot with us connecting families.

And so, some of this was an adopt a floor type program where certain pediatricians and primary care doctors would you know, take it upon themselves as their job to connect each patient on that floor with their loved ones, once each day. If the family member had an I-phone or smart phone and were able to do facetime or some other video visit, we had over 1,100 tablets, I-pads that we procured and received as donations and these were put on basically wheels, stands to be able to wheel in and out of rooms and be able to be clean between different patients rooms but to be able to connect the patients via video visit was a priority for us.

I would like to mention that on a case by case basis, if it was end of life, if it was an unaccompanied minor for deliveries, we did allow patients to have visitors come in. But this was a patient experience priority. This was a palliative care priority. This was we don't want to have anyone not be able to say goodbye. We don't want to have anyone die alone in the United States even in the middle of a pandemic.

So, a lot of our staff and volunteers stepped up. They were the ones at the bedside holding the

patients hands in their last moments. So, the difference is in the two week pilot, what we were allowing was visitors for all inpatients and so, no more than four hours a day. And so, at Jacobi and Coney Island, the four hours between 1 p.m. and 5 p.m., Coney Island took advance appointments to be able to give someone the education and kind of plan for it. Jacobi did not take appointments, so there are different ways of meeting the states stipulations and requirements around this.

North Central Bronx actually split it into two, two hour blocks. One in the early morning and one in the evening to allow those who work a kind of day job to be able to come in the evening. All three were very successful in terms of the feedback, in terms of visitors following you know, wearing the masks, hand hygiene, PPE if they were visiting what we would consider a hot zone and it was very encouraging and I think it was going well here along with the 20 other hospitals across New York State that they said, you know, let's scratch phase two of the pilot and lets just allow all of the hospitals and group homes to have limited visitation.

So, we are super excited about this change today. We are going to do this in a safe way to ensure that we will all be able to continue allowing visitation.

CHAIRPERSON RIVERA: Okay, thank you. I want to make sure that my colleagues are able to ask questions as well. So, I think we have Council Member and I know that Emily is moderating. I was just going to call up Council Member Levine if that's okay.

SERGEANT AT ARMS: Time starts now.

COUNCIL MEMBER LEVINE: Well, thank you so much Chair Rivera and great to see the team from H&H, Dr. Wei, Dr. Wallach. In your opening remarks Dr. Wei spoke in some detail about H&H's work on testing and contact tracing. And so, I did want to follow up on that and I want to start by commending you for the amount of data you have been publishing, all on your website to really help the public understand the progress of the contact tracing work and it's been very helpful for us in the Council to monitor the progress in the program.

And you mentioned just how far we've come in testing. The truth is we probably have 100 times the testing capacity we had back in March and that's a

really big deal. Much of that is being done by private clinics like the City MD etc. How many tests are you doing daily out of H&H facilities? Do you know that number?

DR. ERIC WEI: So, I'm going to ask Andrew who plays a huge leadership role in our T2 program. Andrew, do you know how many tests we are doing in H&H only testing sites and facilities?

I think Andrew is on mute.

DR. ANDREW WALLACH: Okay, thank you. There you go, I was unmuted. Apologies for that. So, currently New York City Health & Hospitals through its site and pop ups are doing approximately 5,000 tests per day through our website.

COUNCIL MEMBER LEVINE: Got it. So, that's only one and six that the city is doing. Are those folks who are walking into you seeking a test or people who are in one of your facilities for another reason? Maybe they are in there for treatments of another condition and you asked them to get a test while they are there. Do you know exactly who is getting those tests?

DR. ANDREW WALLACH: Yes sir, thank you Council Member Levine.

So, absolutely, it's a combination of both. We have a very rigorous and busy walk-in testing through our tents that we set up at each of our facilities. But in addition, we are now pivoting to any patient who comes in for routine care in ambulatory, to encourage those patients as well to get a diagnostic test. So, it's a combination of both.

DR. ERIC WEI: Dr. Natsui could weigh in on testing in the emergency department.

DR. SHAW NATSUI: Good morning. In the emergency department, we have continued to test all patients who are being admitted to the hospital for COVID as well as particularly any sort of transfers by immediate surgical needs. And now that we have greater expansion of our capability to do tests, we could essentially test all patients who are also being discharged from the emergency department especially those with concern for a lower acuity COVID-like illness who again, do not need to be hospitalized thankfully but we do want to test.

So, we are encouraging our emergency department to do that as well.

COUNCIL MEMBER LEVINE: Sorry, I had a mute problem there. We had some construction noise I wanted to spare you all in the background.

The progress that you've made in contacting people who tested positive is really important and it seems like we're even in a better place than we were a week or two ago and we see that as some of the data you are publishing.

The next big question is, once you identify someone who has been exposed or someone who has tested positive, to what extent are they isolating or quarantining for the full period of their being contagious? Can you tell us for example how many folks are taking up our hotel option on a given night. I know we have 1,200 rooms but would you know last night on a given night, how many folks are hoteling and can you give us any numbers on how many people on a given night are under quarantine supervision? And I may go on mute while you speak to spare you background noise and if the staff can just monitor that and unmute me when I speak.

Thank you.

DR. ANDREW WALLACH: I can start and say that the majority of patients who are separating or isolating

are doing so at home with a very small percentage of those folks actually taking —

SERGEANT AT ARMS: Expired.

DR. ANDREW WALLACH: Our offer of hoteling services.

COUNCIL MEMBER LEVINE: My time is actually now expired so I won't go on. I think that last point about the limited number of people hoteling is pretty significant. This virus spreads —

CHAIRPERSON RIVERA: You can have more time.

COUNCIL MEMBER LEVINE: Thank you Chair. This virus spreads in crowded apartments. It's probably one of the main drivers in New York City and other places. I know you are aware of that but if you have vulnerable people at home, it's really high risk to have one sick patient in a department or other crowded home.

So, we do have to figure out this hoteling challenge. Maybe it's offering financial incentives for people who don't have the ability to telecommute, some sort of income replacement. Maybe it's offering childcare or elder care. I've heard anecdotally of people who don't want to go to hotels because they

would have people at home who would have a hard time without their supervision.

Do you have any leads on the kinds of policies we can put in place to encourage people to isolate in hotels?

DR. ANDREW WALLACH: Yeah, so I will say as an initial statement that when the tracer speaks for the individual who has a positive test, that's one of the first things they do is access the ability for that patient or that individual to safely and effectively isolate at home. There are very significant discussions. We have scripts going over all that level of detail including if you are sharing beds, you know, how to sleep. You know, head to toe, you know opposite direction as your partner. Not to share bathrooms and all of that level of detail.

So, all of that is discussed. In addition, we are providing wrap around services for folks who choose to separate or isolate at home. Making sure things like groceries can be delivered if they need that or medication. We're even permitting and providing tech services. If you need your dog walked because we don't want folks leaving their homes if that's where they choose to home isolate.

So, there is a pretty extensive education piece to this and if it felt that the individual is unable to be able to self-isolate at home effectively, they are strongly encouraged to take advantage of our hoteling services.

COUNCIL MEMBER LEVINE: You mentioned education, I know you understand how important outreach is. We have to build confidence in the program, especially at this time. I know people distrust government and they are concerned about any kind of aggressive enforcement and this is a major challenge.

I understand that we're or the city is about to put out an RFP for community groups to be brought on to do that kind of outreach. Do you know the timing of that because I do think that that is extremely important.

DR. ANDREW WALLACH: Yeah, so I know that one of the most important things as we hire up members of the Test and Trace Corps, that it is really critical that we hire folks from within those communities right, for the exact reasons that you just mentioned Council Member Levine.

It's about trust and making sure that those patients feel comfortable. The information that is

being delivered to them and that they feel that it is safe. So, as a main tenant of the Test and Trace Corp is about hiring folks within those communities who will then literally be going door to door to be able to provide that interaction with those individuals and establish that trust, answer their questions and reassure them with any issues they have.

COUNCIL MEMBER LEVINE: Yes, that is important and just the last thing and then I'll pass it back to the Chair. I appreciate the time.

As far as I'm concerned, the ultimate measure of our success in the testing, tracing, quarantining, all of that is how many of the new infections are occurring among people that we had, that were already on our radar through the tracing program. That we understood the chain of infection. We know that for the majority of new cases, we're still at community spread and we have to worry that if you are out in public, I mean, who knows who could be contagious out there.

I understand it's in the lifecycle of contract tracing but can you give us an early estimate of how

many you can identify the source of the infection for people who are newly confirmed as positive?

DR. ANDREW WALLACH: You mean, I'm sorry, the question is the number of contacts for somebody who has recently been identified?

COUNCIL MEMBER LEVINE: Yeah, so we have about 300 newly confirmed cases a day according to the state data. I think the city data is a little different but, so I think we have about 300 new cases a day and the question is, how many of those are people that we knew about because they had been identified as a contact through our tracing efforts and how many are just popping up unknown indicating we still have broad community spread?

DR. ANDREW WALLACH: Yeah, okay, yeah, I apologize, I do not have that level of detailed information today but we can circle back to our team and get that to you.

COUNCIL MEMBER LEVINE: That really is the ultimate. That's like almost the one data point that matters most ultimately and I know it takes time to build to that but that's the kind of thing that we really do want for long term. So, thank you so much H&H and thanks again to the Chair for your leadership

on this issue and this hearing and for giving me the extra time.

I'll pass it back to you. Thanks everybody.

CHAIRPERSON RIVERA: Thank you so much. Are there any other Council — oh, I would like to acknowledge that we've been joined by Council Member Ayala. If there are any questions from my colleagues, you can raise your hands and we will get right to you. I'm just going to ask a couple of more questions to give them a minute to decide.

I wanted to just ask about preparing for the second wave. I did see a press release I believe it was yesterday on how Health and Hospitals are re-engineering emergency departments and clinics across its system to provide safe care after the COVID-19 surge which included some physical changes that are happening to the 11 emergency departments.

So, I wanted to ask what measures are the hospitals taking to safely continue treating patients with COVID-19 while expanding non-COVID-19 related care and procedures. And if maybe you can just mention anecdotally or provide some details exactly on how you are redesigning the emergency departments in the waiting rooms? Because the press release says

you are doing redesign but I didn't really see any details. So, can you tell us a little bit about that?

DR. ERIC WEI: Absolutely. So, I'll start and then have Dr. Natsui add to it. So, we've actually walked all 11 of our emergency departments with those four central office teams as well as facility leadership CEO,CMO,CNO as well as emergency department leadership and the facility staff at each of the hospitals. And what we had were high level principles. We want to incorporate social distancing wherever possible. When social distancing is not possible, we want physical barriers. We want to use video conferencing as much as possible to reduce the amount of face to face within six feet of both you know, for PPE, for better communication right. For me to be able to speak to you without wearing a mask and you know, hat and eye protection and the gown, right. It's much more human experience but also safer because I'm not within six feet of you. How we are flowing patients, so what we're doing is depending on the community prevalence and the number of patients that are coming unsuspicious, what we call a person under investigation, we need to be able

to flex and [INAUDIBLE 1:05:18] thinking of it like an according, right.

So, at the peak, the entire ED was a hot zone, right. Every patient who come in, they are COVID positive until proven otherwise. Now, I'm pleased to announce that we're seeing very rare cases suspicious for COVID.

So, it is almost back to "normal" infection prevention protocols where we can put patients with these influenza-like illness or screen positive for symptoms or exposures into isolation rooms. And so, we've been working on hot zones, more likely COVID. Cold zones less likely COVID. Let's utilize our isolation rooms until we have definitive testing back on patients. You know, keep them isolated from the rest of the patients in the emergency department.

Other things is how we do radiology, how we transport patients if they are going upstairs or if they are going to get a CT scan to avoid going through hot zones, if it's a cold zone patient and vice versa. Talking about how we could separate out the waiting rooms with two separate patient pathways depending on initial screening and leveraging technology at metropolitan. When you walk in their

front door, you are met with a screen and then there is a triage nurse on the other end of that video visit who is asking you the symptoms and the exposure questions for COVID.

If you are determined to be more suspicious, you go through Door A. If you are less suspicious for COVID, you go through Door B, right.

And so, those are a few of many examples of how we are doing this. Air flow in terms of negative pressure for entire pods or asthma rooms is work that we're doing. UV lights in our emergency departments to help with infection prevention. We talked about plexiglass.

But Shaw, do you want to add anything to my answer?

DR. SHAW NATSUI: Sure, and thanks doctor. I think he covered it very comprehensively. I think all of these are different strategies for us to make clear to our patients that we are safe and we are here for them and we want them to come into seek the care that they need. All of these strategies really organize under these buckets around designing or redesigning patient flow, incorporating distance. Distancing as Dr. Wei mentioned both in terms of

space, physical barrier, and virtual distancing where possible.

And then to the question around physical construct around repurposing or re-envisioning how zones can be designated, so that we can appropriately re-stratify patients and keep both their station within an emergency department visit but also their pathways through that and upstairs safe as possible.

So, I think a lot of the technology components to this as well from the front door on in are a major part of that.

CHAIRPERSON RIVERA: So, how many negative pressure rooms are being added per hospital? How many isolation rooms for a hospital?

DR. ERIC WEI: So, I have to come back with you with the exact numbers for that but what we are doing — thinking about right, if we have another surge, individual isolation rooms is not going to be the answer just like it wasn't the answer in March and April. We quickly overwhelmed that and so, what we're doing is looking at under pressure where did we surge to nearby space, near the emergency departments or thinking about our pediatric emergency departments when no pediatric patients were coming in or our

psychiatric emergency department or just other old clinical space that was near the emergency department. How do we formalize oxygen supply? How do we formalize power for ventilators? How do we formalize monitors and ventilators in there? How do we make those negative pressure pods.

So, it's thinking less like a [INAUDIBLE 1:09:38] right where you have one or two patients at a time and more like, what would you do if 100 potential COVID patients at the same time — how do we keep them separated for those who are seeking care less likely from COVID. And so, talking about an entire pod being made negative pressure. Making sure there is not air that is shared between that pod and other pods in the emergency department or other units within the hospital.

And so, a lot of engineering and facilities work to make sure that the air flow, especially in cooling season like we're in right now. It's so hot outside, it's very difficult for our HVAC's to take in 100 percent outside air and cool it down to a safe temperature in our hospitals and then right in the middle of winter, heating season same thing.

How do we use Hepa filters, how do we use UV light, how do we keep our patients and our staff safe?

CHAIRPERSON RIVERA: Well, I only ask because when I went to go get my test in Queens Hospital as well, again, very, very pleasant experience and I let the CEO know of that. It happened in a tent also outside of the hospital.

Is triage still continuing tents outside of H&H buildings as it was done in the past few months or have you kind of officially transitioned that?

DR. ERIC WEI: We've officially transitions away from that. Like we mentioned, the volume is much lower now and the number of potentially suspicious COVID cases is much lower now.

So, I'd say across all 11 ED's were more than normal pre-COVID triage. The difference is that we're asking COVID type questions or screening questions.

CHAIRPERSON RIVERA: Okay, well, thank you very much and I just wanted to — I know that the Committee has several detailed finance related questions regarding revenue impact, systemwide financial outlook, patient outreach and budget transparency

that it would like to examine with H&H and OMB and I know because of the strain and the demand beyond your capacity that we kind of — we did not have a budget hearing officially.

So, I'm just going to ask if you all could commit to setting up a meeting, a briefing with all of us around the room with the relevant people at H&H and OMB to discuss those questions that we provided in the very near future.

DR. ERIC WEI: Yes, absolutely.

CHAIRPERSON RIVERA: Okay, great. I appreciate your commitment and clearly this is to figure out how we can best support each other and then always, always, always pushing transparency.

So, I just want to thank you all for your testimony. I really appreciate you taking the time today and as you mentioned, coming to two of our hearings this month. It means a lot to me and members of the public who I think really needed to hear a lot of the comments that you made today and in showing the H&H is indeed ready to see patients and thank you all for your work.

Thank you very much.

DR. ERIC WEI: It's our pleasure and thank you for your advocacy and collaboration and partnership.

DR. SHAW NATSUI: Thank you.

MODERATOR: Okay, so we have concluded Administration testimony and we will now turn to public testimony. Once more, I'd like to remind everyone that after the first panelists, individuals will be called up in a panel of two or three.

Council Members who have questions for a particular panelist should use the raise hand function on Zoom. You will be called on after everyone on that panel has completed their testimony.

For panelists, once your name is called, a member of our staff will unmute you and the Sergeant at Arms will give you the go ahead to begin after setting a timer.

As a reminder, there maybe a few second delay after you are unmuted. All testimony will be limited to three minutes and please wait for the Sergeant to announce that you may begin before delivering your testimony. The first panelist will be Zeynep Sumer King from the Greater New York Hospital Association.

SERGEANT AT ARMS: Time starts now.

ZEYNEP SUMER KING: Thank you so much. My name is Zeynep Sumer King, I am the Vice President for Regulatory and Professional Affairs at the Greater New York Hospital Association.

We proudly represent all hospitals in New York City, both not-for-profit and public and I lead GNYHA efforts on healthcare quality — sorry, healthcare quality improvement and infection control.

Thank you so much for the opportunity to talk with you today about how New York City hospitals are working to make sure that people can get care during this uncertain time and how hospitals are incorporating preparedness into everything they do.

Hospitals in their ambulatory care networks did not stop serving patients during the COVID-19 pandemic. I think we heard that from H&H. We never really closed or definitely did not close particularly for their most urgent and necessary medical needs.

They also greatly expanded their telehealth capacity virtually overnight to ensure their patients have access to medical professionals at all hours. Unfortunately, however, this unprecedented crisis still forced many New Yorkers to defer their

healthcare and as time has gone on, their needs have become much more acute.

As of last Saturday, the number of COVID-19 patients in New York City hospitals is down 95 percent from the peak however and understandably though, many New Yorkers are wondering if it is safe to get their care in their local hospital.

So, I'd say the answer is yes. Hospitals and doctors are ready to take care of you with the strongest safety measures in place to protect you from contracting the virus.

In concert with city, state and federal authorities and evidence based public health guidance, hospitals have added to their existing infection control procedures. Some additional measure to stop the contagion. These include separating coronavirus patients from others physically and with barriers. Aggressively screening for the virus at all points of entry. Testing patients and healthcare workers and optimizing their handling systems, among others.

People may also notice some changes to the processes and procedures when they seek care including mask requirements, strong messaging around

hand hygiene, social distancing and waiting rooms and reserving early morning appointments for vulnerable patients.

People may also notice some new technology in certain areas, like the emergency department or at entrances for screening and triaging patients safely.

New York City's health systems and their ambulatory care networks have already resumed most of their procedures that they offered before the pandemic including routine outpatient procedures and they prioritize deferred care in particular.

In fact, hospitals and their ambulatory care networks are the single largest providers of healthcare to the Medicaid patient population. Hospitals provided more than 15 million ambulatory visits in 2018, including primary care, mental health, substance abuse and surgery services.

SERGEANT AT ARMS: Time expired.

CHAIRPERSON RIVERA: We will certainly give you a couple more minutes.

ZEYNEP SUMER KING: Thank you. I'll be quick. I'll wrap up.

You know, I'll just cut to the chase. We can't stress enough how important it is for people to not

delay their care. We are not seeing a return to pre-COVID volume for visits and procedures and in response, earlier this month, Greater New York Hospital Association launched a major media campaign to inform the public that hospitals are safe and ready to treat non-COVID-19 patients.

The campaign includes television ads including Spanish language ads, digital ads, newspaper cover wraps, print ads and mail pieces directed particularly at hard hit communities.

Finally, I want to address what hospitals are doing to prepare for future resurgence of COVID or other pandemics and including the possibility that a COVID-19 resurgence could coincide with this years flu season.

We know that the virus will likely continue to be a significant consideration for the healthcare community in the future, so they are planning accordingly.

During the pandemic, New York City Hospitals dramatically increased their capacity to handle the patient surge and they stand ready to do so again should the need arise. They are also working to ensure that extra supplies including ventilators and

protective equipment are available. Hospitals, Greater New York, and all levels of government are working together and carefully monitoring emergency visits and have developed a dashboard that we're looking at on a daily basis. And that is serving as our early warning system for such a surge.

I want to thank you for the opportunity to testify on this critically important issue. GNYHA and our member hospitals are committed to reopening safely and stand ready to make sure every New Yorker gets the care they need.

I'm happy to take any questions.

CHAIRPERSON RIVERA: Thank you so much for your testimony. I wanted to ask a couple questions similar to what I have asked H&H.

I want to ask how is access to vaccinations, preventive care, primary care, and dental care been impacted by the pandemic. You mentioned it but did you give percentages? I'm sorry if I didn't catch that.

ZEYNEP SUMER KING: I did not give percentages. The percentages I heard Dr. Wei and others from H&H cite are similar to what we're hearing from the other large New York City healthcare systems. Across the

board, there was a dramatic decrease in ambulatory visits including some of the specialty areas you mentioned, dental obviously was at zero throughout the pandemic.

I think certain illness that was emergent obviously. We are seeing a very slow rise of some of those numbers. I'm hearing across the board it's still pretty low though. I think again, Dr. Wei said somewhere in the 40 percent range and I'd say that's pretty accurate for other systems as well. It doesn't sound like there are any outliers in that area.

CHAIRPERSON RIVERA: Okay, so and in terms of your media campaign, I haven't seen any and that's not anyone fault. I mean, I know they are in print. They are on TV and are you also, I think you mentioned English and Spanish but you are doing it in multiple languages. You said you are targeting hard to reach communities or communities that were disproportionately impacted.

Can you just talk a little bit about that and how you are working with — you are engaging with maybe community based organizations who help many, many

people navigate this process or can you just give us a little bit more background on that?

ZEYNEP SUMER KING: Sure, and I am not directly involved in the ad campaign itself. I do know there was a specific focus on reaching those hard hit communities, communities of color and those that are disadvantaged that have struggled with access to care.

We are focused and our communication specialists are very much focused in making sure these ads and the communication in various different formats is reaching those communities. We also know that our hospitals are communicating through their local community boards to reach all levels and all people in their communities. They know it better than we do and they are much more connected in their communities and we're hoping the ad campaign supports those engagement efforts. And we're happy to share the ad campaign with you.

CHAIRPERSON RIVERA: Yeah, no, send it to me, that sounds good. You said community boards, do you mean the Community Advisory Boards for the hospitals?

ZEYNEP SUMER KING: That's right, that's right.

CHAIRPERSON RIVERA: Okay, and so, I also want to ask H&H as I mentioned in their press release, they are physically trying to re-engineer their spaces to plan for a potential second wave amongst other things and in terms of actually expanding their capacity and the services to get back to a 100 percent pre-pandemic.

So, what measures are the other hospitals taking to safely continue treating patients with COVID-19 while expanding non-COVID-19 related care and procedures?

ZEYNEP SUMER KING: I don't think I can speak specifically to exact — the specific hospital level engineering controls, but we have spoken, I actually speak regularly with the lead hospital epidemiologist and infection control clinicians at each of the hospitals and I know they are spending a lot of time thinking about physical space as well as engineering controls. Just a lot of the things you heard from H&H physically separating COVID, non-COVID hot, cold areas in the emergency department.

Many have been thinking about for flu, in anticipation of flu season and as they expanded their technology over the last couple of years, they had

already started to implement technology packed isolation rooms for triage of potentially infectious diseases like flu, like COVID.

So, they are certainly enhancing those areas. We know they are thinking about entry and egress out of certain areas should people come in and then be diagnosed and need to be separated immediately. So, a lot of the same types of physical controls that you are hearing about and then, again, as Dr. Wei mentioned, hospitals are and I guess everybody really are thinking a lot about air flow, filtration, direction, and you know, just generally air exchange and the speed at which you can conduct air exchange to keep things flowing, especially in the summer months.

So, a lot of those types of controls and you know, including multidisciplinary teams in the hospital, infection control, facilities, engineering, and technology all to come up with solutions. So, they are doing many of the same things that you heard.

CHAIRPERSON RIVERA: I just want to acknowledge we've been joined by Council Member Reynoso. Well, thank you. Thank you very much. Are your hospitals

allowing — do any of the voluntary hospitals currently allow visitation?

ZEYNEP SUMER KING: So, the visitation policy, so I believe it was — I apologize I don't have the exact number. I believe it was 20, just over 20 hospitals that participated in the two week pilot that you heard about. As of last week, they've all been permitted to expand their visitation policies of course in a very controlled way, four hours a day. Keeping a log, doing extensive screening and temperature checks and they are doing that. It's not uniform across the board; they do have to register their intent to expand their visitation policy and then give the state 48 hours before they actually implement.

So, there is definitely — I'm not sure the exact number of hospitals that have registered that intent but I can get that number for you.

CHAIRPERSON RIVERA: I would appreciate that and just my last question is, how much of an impact has decreased billing for nonessential procedures impacted hospital budgets and to what extend has the impact of declines in revenue related to nonessential

procedures varied between Greater New York's public and private member hospitals?

ZEYNEP SUMER KING: Yeah, and I can't speak to the exact numbers but I do know there has been a tremendous loss in revenue and as you know, New York City hospitals already have a very slim operating margin and so, we do — we are seeing hospitals in financial distress and this is across the board. I know just from a few of our health systems, their monthly losses was in the hundreds of millions of dollars and they are certainly tightening their belts but we are not diluted by the fact that there is probably some difficult times to come.

So, you know, I think of course in those safety net hospitals are always impacted much more disproportionately and the federal and state support are going to be crucial and we're definitely advocating that New York City as a hard hit hot spot get the funding that it deserves from those governments. We appreciate your support actually on that.

CHAIRPERSON RIVERA: Well, thank you. You are welcome. So, well, I think that's all. I mean, there's a couple things I hope that you will get back

to me on including some of the numbers on visitation, on finances, on a couple of the procedures that I asked specifically.

So, okay, one last thing. We did receive a question, I just wanted to ask you. On temps and surge staff from the height of the pandemic, how many of those staff are still working and are being rolled over to full time or provisional positions and how is surge staffing being planned for future outbreaks? Any differences to how it was done during the height of the pandemic?

ZEYNEP SUMER KING: I do not have the numbers for you. I can get those; I can try to get those. So, staffing is a big issues and it's something that obviously we've thought about before the pandemic but really had no idea how we would be impacted during the pandemic and many of the hospitals and health systems shifted their staff from outpatient ambulatory areas. Created extensive training programs and moved them into the areas where COVID patients were being cared for. That infrastructure is already in place and will only be bolstered as we prepare and brace ourselves for a potential second surge or another pandemic down the line.

We do have some work to do around staffing and accessing or dipping into voluntary and retired professionals. We are actually actively evaluating that and trying to look into how we might streamline what was used during the pandemic. It was a tremendous effort to recruit volunteers and they were deployed throughout but we can always improve. So, we're thinking through those steps and those activities and the infrastructure that we need to put in place.

As for, I'm so sorry, I missed the last part of your question or I forgot it.

CHAIRPERSON RIVERA: Ah, it's okay. It was in terms of lessons learned and how you are rethinking staffing levels in preparation for a second wave and specifically on temps and surge staffing. You started off by answering that you couldn't quite get me those numbers but I imagine that everyone here has lessons learned.

ZEYNEP SUMER KING: Yeah. Yeah and you know there were some specialty staff or special skills that emerged during the pandemic. For example, at one point there were a lot of people on ventilators and so, they — for an extended period of time and

those individuals went on dialysis and we have a limited number staff trained in those areas and on using dialysis machines in the ICU but there was a lot of cross training very quickly in identifying staff, other specialists in other parts of the hospital that have transferable skills and we'll definitely tap in — document those lessons learned for a future surge.

In terms of the use of temporary and other staff, volunteers, I do know there are still some in place in the downstate region, so New York City included and I know you know, some of the regulatory flexibilities around licensure and credentialing and all the different staffing related wavers were tremendously helpful. We are in the process of advocating for the extension of those waivers because there are as I said, still volunteers in place that we'd like to keep on hand as we still you know, we still have COVID cases and we're still in a state of emergency.

So, that would be another lesson learned is that those waivers coming very quickly was helpful and we definitely need to maintain them until we know we're in the clear.

CHAIRPERSON RIVERA: Understood. Well thank you very, very much. I look forward to you getting back to us with some of those answers and I appreciate your testimony.

ZEYNEP SUMER KING: Thank you so much.

MODERATOR: So, seeing that no other Council Members have any questions, we will now call on the second panel. So, the second panel in order of speaking will be, Ralph Palladino, Marie Mongeon and Anthony Feliciano.

So, I will now call on Ralph Palladino.

SERGEANT AT ARMS: Time starts now.

RALPH PALLADINO: Good day. Local 1549 members are members that work in all city agencies: Health & Hospitals Corporation, NYPD, and our overwhelming women of color.

The Black Lives Matter protest going on in New York and around the world speak to the life and death needs of communities of color facing all forms of racial discrimination. The COVID pandemic has focused a light on healthcare disparities in the city. New York City Health & Hospitals plays an essential role in these communities in saving lives,

providing decent jobs, and this in turn helps keep the communities, local community economics alive.

The clerical duties and functions are key to generating income for New York City Health & Hospitals and translation services that provide face to face translation services which is preferable than that being done by phone according to New York City Immigration Coalition. In greeting patients, they make them responsible for generating the good will, comfort, security, the patients entering the healthcare facilities.

Call by some to reducing any public services, following the layoff of workers, especially in public hospitals and SNAP as well, which is related to healthcare is wrong. Services will suffer, jobs will be lost. We agree that the funding needs can be found — money can be found from the reduction of the New York City Police Department Budget, exclusive of civilian employees. They are not the problem with policing in the city.

We believe that the State of New York needs to step up and assist our public hospitals. The state distribution of funding has always been unfair to public hospitals. The state is expected to release

the Savings Allocation Plan to cut $13 billion because of the pandemic.

The City Council together with the City Comptroller and the Mayor, let's join the Mayor to speak up together and tell the state leaders that cuts they voted on relating to the city support in hospitals which equal $200 million done April 1st by the State, should be reversed. Any new cuts to state aid is not acceptable.

Our members are asking, where is the shared sacrifice in this crisis? We are not properly being compensated and face layoffs and disease while the rich incorporations do not even pay their fair share of taxes. If the head of Amazon can purchase five floors of a penthouse for $98 million while this company pays virtually nothing in taxes, then we are sure both he and his company should be paying their fair share.

We thank the Mayor and the City Council —

SERGEANT AT ARMS: Time expired.

RALPH PALLADINO: For their support. May I Madam Chairwoman speak as a patient just for very brief?

CHAIRPERSON RIVERA: Very briefly Ralph.

RALPH PALLADINO: Okay. Telecommunication, I've been a Bellevue Hospital patient for 40 years as well as working there. I've had issues with telecommunication as it personally goes to dermatology and asthma. I think it's basically useless. You need to be seen and heard etc.

In terms of primary care, my primary care didn't help. It's okay but even the primary care, when I get my blood pressures done outside, they are not the same as when my doctor actually does it in front of me.

I also have not been able to get my tests done. Blood, urine, and other tests done at this point while I'm waiting to be seen and that is important as well. So, telecommunicating I believe has its place but I think we have to look at the testing and we have to look at not overdoing this telecommunicate.

Thank you.

MODERATOR: Thank you. I will now turn it over to our next panelist who is Marie Mongeon.

SERGEANT AT ARMS: Time starts now.

MARIE MONGEON: Good morning. My name is Marie Mongeon and I am the Director of Policy with the Community Health Care Association of New York State.

We represent all of the state and city's federally qualified health centers. Our health centers serve 1.4 million annual at more than 480 sites across the city and many of our communities have been some of the hardest hit by COVID-19.

In the city, 16 percent of our patients are uninsured, 62 percent are enrolled in Medicaid or Chip, 86 percent are people of color and 35 percent are best served in a language other than English.

When Governor Cuomo put New York State on pause in early March, Health Centers saw dramatic and instant decreases in in-person visit volume. Across the city, visit volume decreased by 59 percent on average. Due to this rapid decline, we calculated that across the state health centers were collectively losing $30 million across the state on a weekly basis.

However, CHC'S rapidly pivoted to providing remote care including implementing programs to deliver service via audio, visual, telehealth, and telephone to ensure that their patients continue to have access to their providers.

Some health centers have implemented unique triaging and outreach programs to ensure that all of

their patients continue to receive care remotely. And all of our health center patients have continued to require comprehensive primary care regardless of their COVID-19 status.

As hospitals begin to reopen, our health centers stand ready to provide follow up care and primary care as they have long before the COVID-19 and during the COVID-19 pandemic.

However, as we start to increase our in-person visit volume, we face some significant hurdles. First, access to PPE will be critical to ensuring that health centers can reopen sites and maintain in-person safety over the long term.

Throughout the epidemic, OEM did not designate health centers as priority providers and therefore health centers were not able to receive PPE from OEM for the duration of the crisis.

Currently, more than 65 percent of visits at CHC remain remote with 23 percent occurring via telehealth and 42 percent occurring over the phone. We would like to see some city and state support for increasing telehealth capabilities both on the patient and provider side.

Lastly, we need some support for capital investment for redesign of health centers to ensure that our health centers have adequate space to ensure safety of both patients and staff. Our members have identified things like revising their waiting rooms, adding testing locations, and renovating HVAC systems for proper filtration.

SERGEANT AT ARMS: Time expired.

MARIE MONGEON: I know I'm out of time but thank you very much and I'm happy to take any questions you may have.

MODERATOR: I'd like to remind Council Members who have questions for particular panelists to use the raise hand function in Zoom. You will then be called on after the panel has completed its testimony in the order in which you have raised your hand.

The last panelist for this panel is Anthony Feliciano.

SERGEANT AT ARMS: Time starts now.

ANTHONY FELICIANO: Good morning. My name is Anthony Feliciano and I am the Director of the Commission on the Public's Health System. Let me just start off that we have a great opportunity now to normalize equity where we haven't had before

because of this pandemic as well. And I'm going to say straight out, we need an antiracist healthcare system. I don't want to go into details about that. There is so much that we can do there but when I hear greed in New York Hospitals speaking a little while ago, I have to be very frustrated because they are the same association that's allowed for our surge and our capacity to go down.

They have been influential in hospital closings and mergers. They have been influential in reducing our bed capacity in the most underserved communities, the ones that were hit by the pandemic and they have the nerve to talk about all these issues.

The governor has the nerve to give them the opportunity and have even Northwell to do studies in our communities about why we were hurt by the pandemic. Why it was a disproportionate hit. That to me is unacceptable. It should be the [INAUDIBLE 1:41:45], our public hospital system and basically society controlling, thinking through what it means to reopen and what it also means in terms of the disproportionate hit that we received. And so that's critically important.

You know the state has the seven measures to reopen, part of it is hospitalization but we are missing a very important measure disproportionately — we are missing that piece. Where are we disproportionately hit in deciding how we reopen, how we move forward when we're even looking at hospital data. That we need more alert disaggregation of data which is critically important.

And I wish and state that we have to look at particular communities. There is a whole bunch of recommendations about healthy birth outcomes. We need to make sure that our women in our community have access in knowing of the impact the pandemic has caused there. We need to look at a way that all the hospitals create some convictional capacity guidelines for PPE and for reusable equipment.

We need to protect our nurses and doctors and all healthcare workers around that. We did not do a great job we should have had in the beginning and we need universal testing rarely accessible and I know Health & Hospitals is doing the best they can. They've been really good in trying to talk with community based organizations on it but we can always do better.

The other part of this for me is that we have an opportunity to really look at surge capacity and think about why Elmhurst Hospital was hit so hard. And we know some of the reasons but why Mount Sinai and Queens and other surroundings — why there is no real correlation. There was no correlation between voluntary and public hospitals the way it should be. We need to investigate and look at that because that was a critical issue.

SERGEANT AT ARMS: Time expired.

ANTHONY FELICIANO: — And when it comes to another spike. Thank you.

MODERATOR: Thank you and we'll now hear from Chair Rivera who has some questions.

CHAIRPERSON RIVERA: I wanted to thank you all of course for your testimony. You know, Rob I was going to ask — have telehealth services provided, been accessible and effective but you answered it a little bit in terms of how we can expand and how we can do a lot better.

I want to ask you also Marie if that's okay, do you think that the city is doing enough to support local clinics and community based organizations impacted by COVID-19? I know you covered it a little

bit actually in your testimony but I just wanted to ask you directly what you think the city could be doing.

MARIE MONGEON: I think the city has certainly been a vital partner for community health centers. With that being said, you know, issues remain. I think one of the biggest things that we've seen in terms of access issues is a lot of our care is happening via the telephone right now because the individuals that health centers serve, they don't have the technical capability or the data plan or the technical literacy to receive care remotely with a video component. And those audio only services are at this time, only approved for a short period of time.

So, for us, the ability to expand our patients capability to receive audio visual services if telephonic goes away will be critical to ensuring that longstanding access. I think we ask ourselves frequently you know, how can we tell our patients who are in some of the hardest hit communities that it's safe to get on public transportation and comment about office setting when other people might not be

taking that option. So, it's something that we certainly would seek additional support on.

CHAIRPERSON RIVERA: I know that Anthony and Ralph, you are both unmuted if you wanted anything to add to that. Before we moved onto the next panel, I wanted to give you an opportunity.

RALPH PALLADINO: I just think what I said before, we need to move forward cautiously on this telecommunication. I think it has value. My Chart is excellent, I like it and there is more communication but some people have to be seen. You have to be there to get that blood pressure and let the doctor do it.

Certain issues, derma, they have to look at your body. Asthma, they have to listen to your lungs. They can't do that over the phone and the little monitor that I have that does the blood pressures is fine but it's all over the place in terms of numbers. So, I'm just cautioning of that. That's all I'm saying.

ANTHONY FELICIANO: I would add in the caution, I think if we're not looking and ensuring that providers, low income individuals and families who don't have the technical infrastructure fully take

advantage of it and still do, that we need to address it and it's a tool. It's not the only tool and my fear is that the system is starting to think about it as a major tool instead of looking at it more comprehensively. And then the other aspect for me is the backlog of what's happening with that, with telemedicine.

And so, we need to understand that. FQEC's have worked to find the infrastructure but it hasn't been easy. And then the other aspect to me is again, that we need to do better in terms of community based organizations being and shaping this because sometimes we're getting things after the fact. We're getting information, we're being told, oh, this isn't how we're going to go about it.

Instead of allowing us to shape it and direct it and that's how we can avoid some mistakes moving forward particularly when spikes are happening in the fall.

CHAIRPERSON RIVERA: And Anthony, as we reopen hospitals, we're also starting to think about the future of care in our communities which you brought up very, very effectively in your testimony. How do you think hospitals should assess future changes they

are exploring to closing or changing services such as with Mount Sinai Beth Israel, just to give you an example.

ANTHONY FELICIANO: I mean, labor and community groups have been calling for a moratorium on hospital closing emergencies. I know that the city doesn't have the full power over that but we need to call for that because we need to really look at bed capacity and surge capacity and think about what that looks in the future and not do it after the fact.

I do think there are issues also with other things. How our Medicaid dollars are being used when serving the uninsured. Public hospitals serve the most underserved but they don't get their fair share. So, I'm a little concerned also about their sustainability including the FQAC's going forward. Because this is a part of a comprehensive safety net system. And the other part of it is, I think there needs to be some call backs on some of these voluntary hospitals who are still making a profit, who got stimulus dollars in a way that they shouldn't have and I'm going to be honest. And also, the city should call for the state to cap all of the salaries of all voluntary hospital CEO salaries.

Why? Just like they do in the public hospitals. There is no reason why our Medicaid dollars should be giving that much money to high level salaries of some of these CEO's. And so, I think there is a lot of things that need to happen in terms of equity and to make sure there is a real correlation between voluntaries and public hospitals and let me clear, there are many good safety nets within the voluntary hospitals system. That's not to take that away but we have an obvious inequity that show given the pandemic.

RALPH PALLADINO: May I just add to that for one second. Deborah Glick my assembly woman had a bill in Albany a number of years ago, calling on the limitation of salaries for the private hospitals and it died. It died in Albany.

And H&H has a one percent overhead, administrative overhead and these other hospitals have 20, 25 and how does H&H expected to survive without state and federal support, I don't know. And thanks to the Mayor and the City Council, you've always been there supporting us and we love you for it but more has to be done by others and we hope that you go out there and advocate at the state. I just

don't want to keep seeing the Mayor alone you know. I'm sure that the Chairwoman does but I'm saying other people.

Thank you.

CHAIRPERSON RIVERA: Thank you so much and thank you to all of the panelists for your testimony, for all the work that you are doing to provide equity in healthcare.

I guess and with that, we will call the next panel. Thank you so much.

MODERATOR: So, thanks again to our panelists. I am seeing that no other Council Members have any questions. I am now going to call the third and final panel. The third panel in order speaking will be Greg Mihailovich from the American Heart Association, Michael Davoli from the American Cancer Society and also, Judith Cutchin from NYSNA and I will now call on Greg.

SERGEANT AT ARMS: Time starts now.

GREG MIHAILOVICH: Great, thank you Chair Rivera and members of the New York City Council Committee on Hospitals. My name is Greg Mihailovich, I am the Community Advocacy Director for the American Heart Association here in New York City.

American Heart Association is the nation's oldest and largest voluntary organization dedicated to heart disease and stroke, fighting heart disease and stroke and the COVID-19 epidemic, this corona, calls us to realign our priorities a little bit because we know that people with cardiovascular disease are more likely to be seriously impacted by the virus.

We also know the communities of color and lower income communities are more likely to have those chronic conditions. Hypertension, diabetes, heart disease that put them at higher risk and they are also facing those systemic obstacles that prevent them from getting that kind of access to care.

Now, first, we have to applaud H&H for their pivot to telehealth and telemedicine in this crisis. It really was impressive to see how they were still able to provide care and I'm encouraged that other people on this call have mentioned self-monitoring as an important tool to compliment telehealth. Now, we just put out a statement, a joint statement with the American Medical Association this week, talking about how self-measure blood pressure monitoring is a validated approach for out of office measurement and that it has high potential for improving the

diagnosis and management of hypertension but there needs to be additional financial investment.

So, there needs to be additional financial investment. To go to Dr. Wallach's point earlier, he talked about how most of his patients have access to these devices and they are covered by insurance. We know that there are a bunch of people who don't have insurance, who don't have that coverage, who don't have that access to these self-monitoring devices. And that's where the additional investment is needed to make sure that people have access to this.

Now, New York City has made this investment before. Two years ago, the city placed blood pressure kiosks in strategically necessarily neighborhoods. You know, so people can manage their blood pressure but in the current climate, it's not really practical for people to go to a public place and touch a device if you don't know when the last time it was cleaned.

So, having smaller devices that people can borrow would actually be an effective alternative. We actually recently partnered with the Queens Public Library and enabled patrons of their Far Rockaway branch. They can borrow a BP cuff for up to a month

with their library card, it was really a popular alternative to using the kiosk in that branch until the libraries were forced to close.

So, by investing in these self-monitoring devices, not just the blood pressure cuffs but also thermometers, all these things where people can kind of monitor themselves at home. Central care can be remotely provided and that's why we're asking the Council to really invest in that. And to Mr. Palladino's point, the self-monitoring shouldn't be a replacement but the idea that people can monitor and they know when they need to seek that in person care versus when they maybe just be feeling a little under the weather. It's important tool.

So, we realize that this is a dynamic and challenging situation. We thank the Council and H&H for everything you are doing to keep New Yorkers safe and American Heart Association remains your partners in keeping New York healthy —

SERGEANT AT ARMS: Time expired.

GREG MIHAILOVICH: And living long and healthier lives.

MODERATOR: Thank you. We will now move on to Michael Davoli.

SERGEANT AT ARMS: Time starts now.

MICHAEL DAVOLI: Chair Rivera and members of the Committee on Hospitals and all distinguished members of the City Council, thank you so much for the opportunity to testify today.

My name is Michael Davoli of the American Cancer Society Cancer Action network. The COVID-19 pandemic continues to impact our city in more ways than we can ever imagine. A recent ACS survey of cancer patients and survivors focusing on COVID-19 affects found many challenges to cancer patients and survivors.

Some of the key finding from this survey include 87 percent of respondents of the pandemic had effected their healthcare in some manner. Of those in active treatment, 79 percent reported delays in their healthcare including 17 percent of patients who reported delays to their cancer therapy and 46 percent said COVID-19 pandemic had impacted their financial situation and their ability to pay for care in some way.

Accessing treatment during this pandemic has been a terrifying prospect for many cancer patients who with a compromised immune system are in a higher risk of contracting COVID-19.

While the growth telemedicine and innovations are a welcomed development and we applaud our city's hospitals for their quick roll out of these programs, we must remain vigilant to ensure that insurance plans and others do not impose different out of pocket costs for patients based solely on COVID-19 related changes. And that we address any of the disparities in care to ensure that they are not accelerated in New York City as a result of telemedicine.

Healthcare practitioners continue to work to balance safety for an immunocompromised population at the increased risk for contracting COVID-19 with timely treatment for and to prevent the spread of cancer. Unfortunately, this results in many delays in treatment for many cancer patients and we must do everything in our power to ensure that patient care is not being delayed and support for patients and care givers is still being provided.

Delays in cancer screenings due to limits placed on procedures and contact with new patients will contribute to many cancers being caught at a late stage when the rate of successful treatment is lower. To wrap up, now more than ever, we need all of those

with cancer to not delay seeking the care that they require and everyone to get their recommended screenings.

When patients do not seek the necessary treatments when symptoms occur and show up for follow up appointments after treatments or access to their doctor recommended screenings, they put their own health at serious risk.

We applaud everyone on this call. We applaud our city leaders and our hospitals for the heroic effort —

SERGEANT AT ARMS: Time expired.

MICHAEL DAVOLI: To roll this out and we thank everyone for their continued efforts.

MODERATOR: Thank you. I will now call on our final panelist and as a reminder, Council Members who have questions for a particular panelist can raise their hand and I will call on you after we hear from our final panelist who is Judith Cutchin.

SERGEANT AT ARMS: Time starts now.

JUDITH CUTCHIN: Hello, I'm Judith Cutchin, I am the President of the New York City Health & Hospitals Executive Council for H&H. I am also a registered nurse for 30 years, 29 working at Woodhull Hospital.

Thank you, Chair Rivera, and the Hospital Committee, for holding the hearing on this very important issue. We are only beginning to understand COVID. We know that we cannot go back to the way our hospitals operated before. We must establish a new normal where safety drives decision making. The continued risk of airborne and contact transmission requires COVID-19 standard precautions including respiratory protection for any staff member coming in contact with the public along with masks and strict screening measures for income patient family members and anyone else in the building.

Every hospital must adapt enhanced prevention or capacity guidelines and begin the migration to reusable equipment and testing for all respirators. Stockpiles must be built so healthcare workers aren't left unprotected during the next outbreak. Essential workers such as delivery transit grocery workers must also be protected. Lack of protection have [INAUDIBLE 1:59:17] nurses along with other workers into protection from the virus. We need an on demand rapid result protection for all frontline workers. All incoming patients at hospitals should be tested.

One antibody test are widely available. They may be used for epidemic [INAUDIBLE 1:59:36] for antibody tests and cannot be used to send workers back to work or to ration their PPE.

The Governor repeatedly claims we are operating one system throughout this crisis but how soon is that — for PPE and other critical supplies. The state must take essential role and coordinate a purchase and distribution of PPE to ensure supplies and delivery where they are needed and not to hassle with the most resources. Healthcare workers must also be able to access paid time, sick leave, regular hospital schedule must be restored including extra paid time off for those who need it in the frontlines.

At risk healthcare workers must receive protections they need to safely provide patient care or be reassigned. We must continue to provide other supports for at risk family members. The hospital much be transparent with workers and the public reporting essential information such as how many COVID patients they have and level the PPE inventory at all plants for screening and the number of staff who has been exposed to COVID-19. Generated revenue

cannot come at the expense of health and safety, elective procedures must be phased in only at the COVID-19 — and to send it automatically if it starts rise.

We must ensure all patients are tested 24 hours prior to admission and COVID specific standard precautions are instituted to operating and delivery room. Hospitals cut staff before COVID-19 and our patients paid the price with the pandemic. Going forward, we need far more staff to protect our patients and we need the same staffing standard in every hospital. With 19,000 fatalities statewide and intermittent risk of —

SERGEANT AT ARMS: Time expired.

JUDITH CUTCHIN: Of outbreak in every community, no hospital can justify later for other reductions in health care.

New York will see another wave and we need to be prepared.

Thank you for your time.

MODERATOR: Thank you to each of our panelists for your participation. I will move over to our Chair for questions.

CHAIRPERSON RIVERA: I want to acknowledge that we've been joined by Council Member Eugene.

I just wanted to ask you all and I thank you for your testimony and for your focus specifically on some of these issues and very, very serious conditions that many New Yorkers have. Whether it's just generally a question. Do you think that enough is being done to reassure New Yorkers that it is now safe to go to the hospital for non-COVID-19 related care services and how can this message be more widely and effectively communicated?

You are all unmuted, so if you can —

GREG MIHAILOVICH: Oh, okay, so it's open to all of us. I mean, I think that there is just — there is only so much you can do. I think it's just multiple touches because this isn't necessarily an intellectual reaction, it's an emotional reaction, a fear reaction.

At American Heart Association, we actually just launched this campaign called, Don't Die of Doubt. The idea Dr. Natsui mentioned that the ER visits are down 42 percent but you know, heart attacks and strokes don't stop because of COVID and I think it's just a comforting message that the care is there and

you know, monitor your health and make sure that people know that they can do this because I don't think it's an intellectual reaction. It's a fear reaction, so all we can do is just you know, continuing the message that we're here for you, watch your health. You know, we always say know your numbers which is why we talk about the BP you know, when they have the self-monitoring, they know when it is getting serious and the idea, it's like okay, now I have to go in person don't just stay at home.

So, that's how we're viewing it. That it's consistent messaging going forward and just you know, hopefully that you reach people because it's not a rational response. I mean, we just have to acknowledge that.

MICHAEL DAVOLI: Yeah, I just completely agree with Greg. You know, the bottom line is everyone needs to do their part to help get the word out. I heard a lot of incredible things today on this call about what the hospitals are doing, what the steps that are being taken to ensure that people are safe. But even me, in my position, I was not aware previously of those steps.

So, I think whether it's the hospitals, you know, themselves, whether it's Council Members, other city leaders helping educate the public and get the word out. I think we need to bang the drum as loud as we possibly can in every way possible to get that word out there that the city recognizes the steps that need to be taken and that they are taking those steps and that ultimately, the risk of delaying your cancer treatment. The risk of delaying you know precautionary measures for related to heart disease far out — you know are far worse than the risk of contracting COVID by coming into one of these hospitals.

JUDITH CUTCHIN: I'd like to — as a registered nurse working in Health & Hospital, I would like to applaud H&H for all that they are doing in preparing for the reopening but of course, there is always room for more.

I believe that each and every employee regardless of their title or their role, need to be proactive in convincing our patients and the community that it's safe to return. We have so many measures in place, safety measures in place that you know, the patients could feel comfortable and ready to come back into

the facility. So, I think that we are on a good path. We still have more to do but we can reach that goal together.

CHAIRPERSON RIVERA: Well, thank you. I agree and I really want to make sure that we're engaging and lifting up our community based organizations, our large nonprofits like you all and really highlighting the work that we're doing and you know, one question that I asked in our last hearing was you know, whether our hospital executives feel like safe staffing should be an issue that is underlined, stressed and highlighted, now that we've seen kind of the conditions and some of the issues that we're experiencing in our hospital systems and to go back to what a previous panelist said, Anthony Feliciano about you know, taking this opportunity to make some real changes.

So, I hope that can happen with the help of all of you and I appreciate all of the work that you are doing and I want to thank you all for your testimony.

MODERATOR: Thank you. So, if we inadvertently missed anyone that would like to testify, please use the Zoom raise hand function and we will call on you in the order your hand is raised.

Seeing no one raising their hands, I will now turn it back over to Chair Rivera since we have concluded the public testimony for this hearing.

CHAIRPERSON RIVERA: Okay, well, thank you so much everyone. Certainly, looking forward to working with all of you. Again, the point of this hearing was to one, give that public education that I think is so necessary to people who are very, very close this issue. Very, very active in this industry and sector who still do not know of all of the things that we are doing to reopen safely.

You know, I would love also for all of us to come together as a sort of round table to make sure that we are working to support each other. So, I hope to be in touch with you in the future and I guess with that, we have concluded public testimony for this hearing and we have adjourned this hearing. Thank you so much. [GAVEL]

C E R T I F I C A T E

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

Date April 1, 2018