New York City Council Hearing

Examining the City's Support of NYC Hospitals During the COVID-19 Pandemic

Committee on Hospitals

Mitchell Katz, M.D.

President and Chief Executive Officer

NYC Health + Hospitals

November 05, 2020

Good morning Chairwoman Rivera and members of the Committee on Hospitals. I am Dr. Mitch Katz, President & CEO of the NYC Health + Hospitals (Health + Hospitals). I am joined this morning by Deanne Criswell, Commissioner of the New York City Emergency Management Department; Jackie Bray, Deputy Executive Director of the Test and Trace Corps; and Maura Kennelly, Associate Commissioner of External Affairs at the Department of Health and Mental Hygiene. Thank you for the opportunity to testify before you on the ***City's Support of NYC Hospitals During the COVID-19 Pandemic***.

I am proud to be here this morning to share the extraordinary response of NYC Health + Hospitals to the COVID-19 global pandemic during the months of the surge. Since the initial coronavirus reports began emerging out of Wuhan, China in December 2019, Health + Hospitals began preparing. From December 2019 to February 2020, our Central Office Emergency Management team met with other NYC agencies and associations to coordinate city-wide COVID-19 activation and response.

On January 21, 2020 Health + Hospitals activated its system-wide Incident Command System Emergency Operation Center. This structure was established to direct response activities and enable quick decision-making. By early March, inter-

agency meetings had become a daily occurrence, and NYC Heath + Hospitals was providing daily updates to City Hall. NYC Health + Hospitals also communicated through emails and calls with City Hall and other municipal partners countless times a day.

By the second week in March, NYC Health + Hospitals converted all routine face-to-face visits to telephone or virtual telehealth visits. Physicians scheduled approximately 170,000 patient tele-visits to keep patients safely at home and reduce the spread of the virus, and behavioral health providers made over 30,000 telephone and video visits between March and April 2020.

In mid-March, all hospitals in the State were mandated to increase their inpatient capacity by 50%, working towards a goal of a 100% increase. NYC Heath + Hospitals activated immediately to respond with each acute care facility developing a 50% surge plan over the course of a weekend. At baseline, NYC Health + Hospitals had ICU capacity of approximately 300 beds. At the peak of the COVID-19 surge, our System cared for over 1,000 ICU patients. I am proud to share that over the course of the month of April, NYC Health + Hospitals created nearly 762 ICU beds – more than any other hospital system in the country – and

added nearly 2,500 medical beds. In particular, NYC Health + Hospitals/Bellevue and Lincoln more than quadrupled their number of ICU beds.

As a way to redesign and expand patient flow options and facilitate safe COVID testing, acute care facilities and large Gotham sites also began constructing external testing tents in mid-March. Tents were added at each of the eleven acute care facilities and seven of the large Gotham sites, and were subsequently added throughout the City to support pop-up testing sites. The testing tents provided patients exhibiting COVID-19 symptoms with a place to obtain testing at a hospital without having to enter a potentially unsafe and over-burdened ED.

The most significant temporary alternate site NYC Health + Hospitals was the Roosevelt Island Medical Center (RIMC). Through this effort, NYC Health + Hospitals stood up 350 temporary acute care beds in unused space in a long-term care facility. This surge site provided a critical outlet for NYC Health + Hospitals acute care facilities when they needed to move low- to mid-acuity acuity patients to accommodate higher-acuity COVID patients.

In addition to this alternate care site, the City leveled the COVID-19 surge across the H+H system by transferring non-ICU and ICU COVID-19 patients from NYC Health + Hospitals/Elmhurst, Queens, Lincoln, Woodhull, and Kings County

hospitals to other public hospitals with more capacity. Over 850 patients were transferred between NYC Health + Hospitals facilities to "level-load" from surging facilities to those with greater capacity between March 20 – April 23. Elmhurst and Queens hospitals were the top two facilities to transfer patients to other NYC Health + Hospitals facilities. Bellevue and NCB were the top two facilities to receive patients from other NYC Health + Hospitals facilities. At peak, NYC Health + Hospitals treated a total of 1,000 critical care patients, an increase from 300 pre-COVID.

As COVID-19 cases surged in New York City, many staff courageously leaned in to battle the virus. Healthcare workers worked longer hours and more days, and we worked tirelessly to augment support. Health + Hospitals developed its own system to identify and onboard volunteers from across the country contracted with staffing agencies and benefitted from a partnership with the Department of Defense to bring in highly skilled temporary workers. We will always be grateful for their dedicated service to our communities. The System also worked with the City's Medical Reserve Corps and the State's volunteer clearing house.

To support our healthcare workers, Health + Hospitals added 5,000 nurses, and 1,500 other health care practitioners, system-wide from March – June 2020. We

also expanded Helping Healers Heal (H3), a peer-led employee wellness program to extend emotional and psychological counseling to the health care workers dealing with the common stress and anxiety caused by the crisis. In addition, each of the acute and post-acute facilities at NYC Health + Hospitals set up wellness/respite areas for staff to use as temporary reprieve from work duties. For those unable to join wellness/respite areas, H3 wellness teams and volunteers at facilities conducted wellness rounds, especially for units with high COVID-19 patient volumes, to address staff's emotional and psychological needs. Those needing support were offered one-on-one or group debriefs and anonymous counseling and, as requested, connections to follow-up services. This included peer support encounters and anonymous counseling sessions with licensed mental health counselors from the Office of Behavioral Health.

Furthermore, to ensure that New Yorkers had a trusted and vetted source of information that they could speak with, NYC Health + Hospitals formalized a clinician-led COVID-19 hotline. If a patient called 311 or the NYC Health + Hospitals contact center with a COVID-19 clinical concern or question, the individual would be transferred directly to a clinician on the COVID-19 hotline. This gave New Yorkers – regardless of whether they were NYC Health + Hospitals patients – an outlet to speak with a trained clinician who had the most up-to-date

and vetted answers about COVID-19. In total we deployed more than 750 clinicians to provide telephonic clinical guidance to more than 4,000 New Yorkers who called 311 every day to help redirect people from coming to the emergency room unnecessarily.

I am proud of the resilience and dedication that Health + Hospitals had to support New Yorkers during the COVID-19 surge, and the work that it continues to do to keep New Yorkers safe. Thank you for the opportunity to testify before you today on this topic. I am happy to answer any questions you may have.

Testimony of Deanne Criswell, Commissioner
New York City Department of Emergency Management
Before the New York City Council Committee on Hospitals
November 5, 2020

Good morning Chairperson Rivera and members of the Committee on Hospitals. I am Commissioner Deanne Criswell, and I am happy to be here today on behalf of New York City Emergency Management (NYCEM). While NYCEM has been actively involved in citywide coordination and multiple operations across the city, state, and federal landscape for COVID-19, I will focus today on items related to our work within the City's public hospital system.

As cases quickly spread across the globe in early 2020, NYCEM started to prepare for the inevitable — COVID-19 in New York City. NYCEM activated the City's Emergency Operations Center on February 1st to implement the federal quarantine directives and build a structure of interagency crisis action planning task forces to rapidly develop policies, procedures, and recommendations. Tasks and responsibilities of the agency evolved to meet the needs of the emergency as we worked on massive operations, including emergency food delivery, healthcare infrastructure capacity, quarantine and isolation hotel operations, continuity of operations, and fatality management. One of the first priorities was to operationalize and expand the City's capability to treat the rapidly increasing number of patients. This included operations to coordinate medical surge space, medical surge staffing, and the procurement of critical medical supplies, including personal protective equipment.

With assistance from our City agency partners, New York State, and the federal government, we stood up temporary hospital facilities in nontraditional settings to care for patient surge if hospital capacity became overwhelmed. This included the Jacob Javits Center in Manhattan, the USNS Comfort naval hospital ship, the Billie Jean King Tennis Facility in Queens, and the Brooklyn Cruise Terminal. Additionally, NYCEM worked with our hospital partners to expand the number of readily available ICU beds in existing facilities in a number of institutions, including the Brooklyn Center for Rehabilitation, the Boro Park Center for Rehabilitation and Nursing, North Central Bronx Hospital, and Coler Hospital. This process provided NYCEM with invaluable experience and information about how to prepare for a second wave and future pandemics.

NYCEM sourced and entered into emergency contracts with healthcare staffing firms that brought thousands of doctors, nurses, and other medical professionals to the bedsides of New Yorkers. We set up a staffing cell that rapidly placed volunteers into hospitals and worked with airline partners to fly them in. NYCEM coordinated the request and placement of medical providers from the United States Armed Forces who provided care in all of our public hospitals. Additionally, NYCEM coordinated the medical reserve corps operation, where medical volunteers were accepted and matched to appropriate facilities in need. In conjunction with these efforts, we issued a Wireless Emergency Alert aimed at recruiting more health care workers to aide in the response. In total, over 5,600 volunteer and contract staff were placed in healthcare institutions.

NYCEM worked with our City partners to help procure critical medical supplies for healthcare facilities through our Logistics Center. In consultation with the Department of Health and Mental Hygiene and the public and private hospital systems, NYCEM facilitated delivery of supplies to facilities in a coordinated fashion and with special attention to particular facility needs, ultimately delivering more than 22 million pieces of PPE. Additionally, we worked with OMB, DDC, EDC, and numerous other agencies to put in place contracts and vet potential suppliers during a time of dire need.

Throughout the pandemic, the City has been keenly aware of the crucial need to share up-to-date information with New Yorkers, especially as guidance and protocols have changed as the virus and the City's response have evolved. The Notify NYC team launched a short code messaging program to ensure New Yorkers receive critical updates about COVID-19. More than 840,000 individuals subscribed to these messages for English, and more

than 31,000 for Spanish—which represents the first time NYCEM has been able to send text message alerts in Spanish via the short code. We translated Notify NYC messages into Traditional or Simplified Chinese, and issued several Wireless Emergency Alerts in English and Spanish to all New York City cell phones. One of our goals as we move forward is to work with our messaging platform and cell service providers to be able to issue these real-time alerts in additional languages, just as the general Notify NYC program provides messages in 13 languages and American Sign Language.

As the world continues to fight this pandemic, we are reminded that while this is a time of uncertainty, we are in this together and we never stop planning, we never stop preparing, and we never stop responding. I am happy to take any questions you may have. Thank you.

New York City Council

Committee on Hospitals

Hearing Testimony:
"Oversight: Examining the City's Support of NYC Hospitals During the COVID-19 Pandemic"

Jenna Mandel-Ricci, Vice President, Regulatory and Professional Affairs

GREATER NEW YORK HOSPITAL ASSOCIATION

Introduction

Chair Rivera and members of the Committee on Hospitals, my name is Jenna Mandel-Ricci, Vice President, Regulatory and Professional Affairs at the Greater New York Hospital Association (GNYHA). GNYHA represents all hospitals in New York City, both not-for-profit and public, as well as hospitals throughout New York State, New Jersey, Connecticut, and Rhode Island. GNYHA is proud to support the City's 55 hospitals and serve as a bridge between them and all levels of government on the COVID-19 pandemic response and other emergency preparedness issues. GNYHA and our members believe health care is a human right and do everything possible to make that a reality, including caring for every COVID-19 patient.

In addition to my normal role leading GNYHA's efforts on emergency preparedness and employee wellness, I serve as the Incident Commander for our COVID-19 response effort, which has tackled issues ranging from surge staffing and alternate care sites to supporting the emotional and mental health needs of our heroic health care workforce. Today I will discuss how hospitals across New York City worked with all levels of government during the initial stages of the pandemic and how we are working together to plan for future waves.

New York's response to the spring COVID-19 patient surge necessitated the largest deployment of health care resources in U.S. history. At the peak of the initial patient surge, there were 18,825 hospitalizations statewide (12,184 of which were in New York City).

Strong leadership, public health measures, and New Yorkers' continued adherence to mitigation efforts have kept infection rates low, especially compared to the rest of the country. Despite recent upticks, COVID-19 hospitalizations still remain low, with just under 1,250 statewide and fewer than 500 in New York City. To date, New York City hospitals have provided care for over 60,000 COVID-19 patients and will continue to do so for everyone who comes through their doors. During the most severe period of the pandemic, New York's health care system bent, but it did not break.

The Initial Patient Surge

In March, New York City hospitals and their dedicated caregivers were thrust into the epicenter of the COVID-19 pandemic and rose to the challenge in unimaginable and unforeseen ways. Hospitals worked around the clock to meet State-mandated increases of 50-100% in staffed inpatient bed capacity.

Surge Staffing

With early impact projections predicting tens of thousands of COVID-19 patients, GNYHA and hospitals worked with the City, State, and Federal governments to activate supplementary staffing resources and put strategies in place to add necessary flexibility to care for patients.

Hospitals and health systems redeployed existing staff from non-hospital facilities and brought in additional staff from staffing agencies and existing partnerships with other health systems across the country. Because the patient surge hit relatively late in the usual nursing and medical school

academic year, many institutions permitted early graduation. Many hospitals integrated these graduates into direct care teams under the supervision of licensed physicians. Others were deployed as scribes or provided updates to family members, freeing up more experienced providers to care for high-acuity COVID-19 patients.

New York City Emergency Management (NYCEM) developed a robust infrastructure to support out-of-state volunteers, including access to flights and hotel rooms. Hospitals also used the New York City Department of Health and Mental Hygiene's (DOHMH) Medical Reserve Corps (MRC) and New York State's Volunteer Portal to supplement their surge staffing efforts. According to late-May NYCEM data, health care organizations contracted approximately 2,000 MRC volunteers in response to COVID-19 needs.

The State and Federal governments issued waivers to allow the rapid credentialing of volunteers and staff with out-of-state licenses in order to facilitate hospitals' surge staffing. Additionally, the Department of Transportation (DOT) issued 12,000 parking permits specifically for health care workers. GNYHA worked closely with DOT to distribute the permits to all hospitals across New York City.

Equipment Surge

The initial patient surge also exponentially increased demand for personal protective equipment (PPE), ventilators, and other supplies. This was a particularly challenging issue given global supply chain contractions due to factory shutdowns in China earlier in 2020.

GNYHA worked with the City to establish a formal resource request process for hospitals and an allocation methodology based on the available supply of PPE. DOHMH and NYCEM began weekly supply deliveries to hospitals starting the week of March 23. These tremendously helpful deliveries were critical to every hospital as they worked to bolster their own supply chains.

GNYHA and our member hospitals worked with stakeholders, the City, and the State to acquire ventilators from State and Federal government stockpiles. Similar to PPE, GNYHA worked with DOHMH, NYCEM, and City Hall to develop an allocation methodology for ventilators.

Creation of Surge Space

To meet the rising volume of patients, hospitals converted existing beds to care for COVID-19 patients and created new beds using non-traditional spaces such as lobbies and conference rooms. Several hospitals also set up alternate care sites such as the Mount Sinai Field Hospital in Central Park and NewYork-Presbyterian's site at Baker Field. Hospitals and health systems collaborated closely with City agencies for additional supplies to support these spaces as well as necessary permitting.

Patient Load Balancing

Throughout the spring surge, hospitals and health systems used patient load balancing strategies in an effort to meet patient needs and relieve hospitals that were reaching capacity. Independent hospitals worked with day-to-day transfer partners and accessed beds available in the Veterans

Administration system. Health systems actively load balanced within their network hospitals, which involved frequent communication among site leadership and transfer center protocols and processes. These efforts resulted in the transfer of hundreds of patients throughout the surge.

Government-Supported Alternate Care Sites

Anticipating tens of thousands of COVID-19 patients, the City, State, and Federal governments worked to rapidly set up Alternate Care Sites (ACS) to relieve pressure on hospitals. Setting up these sites was complicated given the intense resources needed to care for COVID-19 patients and extensive collaboration among hospitals and government. With the introduction of Northwell Health as a clinical management team, the Javits Center played an important role in caring for COVID-19 patients during the recuperation phase, freeing up critical in-hospital space for more acute patients.

Preparing for Future Waves

With the fall upon us and cases on the rise in Europe and across most of the United States, hospitals, the City, and the State are all preparing for an increase in cases and hospitalizations. We must all underscore the importance of adherence to public health guidance such as wearing masks, social distancing, proper hand hygiene, and avoiding unnecessary travel. Hospitals continue to work with the City and the State on addressing micro-clusters as they appear. This strategy is critical to keeping infection rates low and blunting a potential second wave. It is vital that hospitals retain their ability to meet the needs of *all* patients in the face of the ongoing pandemic coupled with flu season.

Testing, Public Health Measures, and Supplies

The City, State, and hospitals are all working to expand their testing capacity to better understand where the virus is and how quickly it spreads. The recent upticks in cases in Brooklyn and Queens, and a slow increase in the citywide positivity rate, have made expanded testing crucial. It allows public health officials to target problematic areas with increased surveillance and public health measures to reduce transmission.

Over the summer, New York State issued an emergency regulation requiring all hospitals to develop and maintain a 90-day stockpile of PPE products. GNYHA has been working to support members' efforts to meet this regulation. New York City's newly established PPE and ventilator stockpiles are an important complement to this efforts. These stockpiles will serve as an emergency resource for health care facilities and organizations across New York City during future patient surges. In collaboration with New York City agencies, GNYHA has shared communications with members and hosted webinars to inform members of these resources.

Surge Planning

Prior to COVID-19, hospitals and health systems already maintained robust patient surge plans, and they learned a great deal from the spring patient surge. Over the last several months, hospitals have been updating and improving their surge plans, with an emphasis on the maintenance of normal operations while also meeting the needs of COVID-19 patients. Hospitals

plan to use phased surge plans that allow them to add beds as needed. Many have also developed detailed redeployment plans that would pull non-hospital-based staff into appropriate hospital roles during later phases of a patient surge as part of their "dimmer switch" strategy.

GNYHA has been working with members and City agencies over the last several months to advance patient load balancing strategies designed to prevent a single hospital or health system from shouldering a disproportionate burden of patients. These methods include:

- Development of a Hospital Surge Indicator that will be collected daily and used by FDNY EMS to inform ambulance destination decisions
- Formalizing and supporting processes to facilitate patient transfers
- Ensuring safe discharge options for recovering COVID-19 patients

Fatality Management

Fatality management was a particularly challenging aspect of the initial COVID-19 patient surge. GNYHA has been working closely with the Office of Chief Medical Examiner, NYCEM, DOHMH, and NYC Health + Hospitals to improve fatality management planning. These include weekly interagency coordination calls; a requirement that all hospitals update their fatality management plans; maintenance of 120 refrigerated trailers to supplement in-hospital morgue space; and creation of a document and resource hub on the GNYHA website that contains all fatality management-related guidance and resources.

Supporting the Health Care Workforce

GNYHA and our member hospitals are committed to the health and wellbeing of the staff at the heart of every hospital. During the spring patient surge, many members expanded existing programming to meet the physical and emotional needs of their staff. In the months since the surge, there has been an emphasis on meeting the ongoing emotional and mental health needs of staff, many of whom are experiencing stress and anxiety personally and professionally. GNYHA is supporting these efforts by regularly convening a Clinician Wellbeing Advisory Group and helping to develop the mental health training initiative HERO-NY with City Hall, NYC Health + Hospitals, the Veterans Administration, and the U.S. Department of Defense. We have also partnered with the American Medical Association to offer the "COVID-19 Caregivers Coping with COVID" survey to members to help them understand workforce impacts and needs.

Protecting Medicaid and Safety Net Hospitals

Hospitals are fighting for their very survival due to the combined cost of the pandemic response and a severe revenue losses due to lower patient volume, fewer elective surgeries, a greater reliance on government payers such as Medicare and Medicaid (neither of which cover the cost of care), and current and potential Medicaid cuts. During the patient surge, the combination of reduced revenue and increased expenses reduced hospital operating margins from a positive 1% to -50%. Because of the pandemic, every hospital in New York State will lose money this year.

Some are contemplating layoffs, which will reduce readiness for a future patient surge. There is a significant risk that hospital revenues will not return to their pre-COVID-19 levels.

GNYHA, like the City and State, is advocating in Washington, DC for future relief packages to include state and local funding to protect New York's health care system. The Federal government has failed thus far to provide the City and State with the necessary funding to cover the massive deficits they incurred from crashing tax revenue and the costs of the pandemic response. As a result, the State may not be able to continue providing $800 million in direct subsidies to safety net hospitals, and may be forced to slash the Medicaid budget by 20-30%. It is imperative that we work together to ensure that the City, State, and our hospitals are made whole.

Vaccine Distribution and Administration

GNYHA and our member hospitals are working with the City and State to develop and implement vaccine distribution and administration plans, including:

- Vaccine storage and distribution
- Vaccine prioritization
- Public outreach and education

Conclusion

Thank you for the opportunity to testify before the City Council on this issue. No matter what happens, New York hospitals will continue their mission of providing the highest-quality care when patients are in need. GNYHA is proud to help them achieve this goal and will continue to act as a bridge between them and all levels of government throughout the pandemic and beyond.

I am happy to answer any questions you may have.

New York State NURSES ASSOCIATION One strong, united voice for nurses and patients

New York City Council Oversight Hearing -Committee on Hospitals: Examining the City's Support of NYC Hospitals during the COVID-19 Pandemic

November 5, 2020

Testimony of the New York State Nurses Association
Presented by Judith Cutchin, RN
President NYCHH/Mayoral Executive Council

Introduction

My name is Judith Cutchin, RN, and I am employed as a nurse by Health + Hospitals at Woodhull Hospital. I am the President of the NYCHH/Mayoral Executive Council, which represents more than 9,000 registered nurses working at Health + Hospitals and Mayoral Agencies.

The COVID-19 emergency severely affected hospitals throughout the state, but New York City area hospitals were particularly hard hit. In New York City during the height of the first surge in March and April, daily hospitalizations averaged more than 12,000, including more than 3,000 ICU level patients.

To date, more almost 258,000 NYC residents have been diagnosed with COVID, more than 59,000 have been hospitalized and 24,000 have died.

The economic crisis that was triggered by the pandemic has also had a disproportionate impact on NY City. The unemployment rate in the City remains at about14%, significantly higher than the rest of the state. City tax revenues are down by about $10 billion, and the City of New York faces on ongoing severe budget crisis that threatens, in the absence of state or federal assistance to lead to layoffs and reductions in vital city services.

The pandemic has also brought into stark focus long-standing racial and socio-economic inequalities in our broader economy and health care system. COVID hospitalization and mortality rates for Black and Latino New Yorkers are more than twice those of white residents, reflecting historic inequalities in safety net hospital funding, access to services, quality of care, distribution of wealth and income, social and economic determinants of health, and the prevalence of Black and Latino workers in the lower paid "essential" workforce that was most

exposed to the pandemic. These structural inequalities will reappear with equal virulence in the looming second COVID surge if they are not aggressively addressed now.

Based on the experience of NYSNA NYCHH nurses during the first COVID-19 surge, it is imperative that we properly understand what happened in March and April, draw necessary lessons and take urgent steps now to prepare for a similar crisis in the fall and winter.

Based on the experience and analysis of the NYSNA nurses who were on the frontlines of the fight against COVID, we believe that the following issues need to be urgently addressed:

1. Inadequate hospital staffing and the need for minimum staffing standards

Staffing continues to be a systemic problem in our hospitals, in both the private and the public sector systems.

At NYCHH and in many of the private safety net hospitals, staffing levels are consistently lower than in some of the large private hospital networks. In addition, even in the private networks there are wide variations between staffing in the "flagship" main hospitals and satellite or borough facilities. Patients with similar diagnoses and severities of illness receive different levels of nursing care depending on where they are hospitalized. A given medical-surgical level of acuity patient may receive care from a nurse with 4 or 5 patients in one hospital and a nurse with 7 or 8 patients in another hospital.

Wide variations in the quality of care received due to a lack of minimum enforceable ratios that apply to all hospitals directly affect mortality and other health outcome metrics for patients. The impact of understaffing is particularly acute when you factor in socio-economic status, race and gender – poor patients and people of color are more likely to suffer adverse health effects. In the context of the COVID pandemic, these inequalities have had lethal consequences.

During the height of the COVID surge, nurses in our EDs, COVID units and ICUs were assigned even higher numbers of patients than usual. At NYCHH, ICU nurses were sometimes assigned as many as 6 to 8 patients (the generally recognized standard is no more than 1:2).

In addition, it should be noted that during the surge, many temporary nurses were hired in our hospitals and regular staff were reassigned to acute and critical care units without proper training or experience in caring for seriously ill patients. This directly impacted patient care and outcomes and also added to the stress on the existing workforce, as experienced regular staff had to care for their own expanded patient loads and assist unprepared temporary staff with their patients.

As the second surge approaches, it is imperative that the City of New York take action to ensure that there are enough staff and that they are properly trained to meet patient care needs. This must include an obligation to maintain minimum safe nurse-to-patient ratios in all of our hospitals.

2. Implement standardized infection control policies and protocols

During the height of the first surge, nurses in our hospitals were forced to try to care for COVID patients under a deluge of conflicting, inconsistent and confusing directives from the federal government (CDC), the state (DOH), the City (NYC DOHMC) and hospital administrators.

This lack of consistent standards undermined the health and morale of nurses and other staff, and most importantly contributed to avoidable and unnecessary exposure to COVID and mortality of patients and staff, including the following examples:

- Unequal and ineffective distribution of PPE to protect staff;
- Constantly changing Infection control standards and protocols, without a scientific or clinical basis, and often driven entirely by shortages of PPE and other equipment;
- Forcing staff to reuse disposable N95 respirators and other PPE that was degraded or ineffective and exposed staff to COVID;
- Failure to procure reusable PPE, particularly reusable elastomeric respirators that could have alleviated PPE shortages;
- Constantly shifting criteria for isolation and quarantine of staff exposed to or infected by COVID, leading to staff being recalled to work while sick or still contagious;
- Refusal to designate COVID as an occupational illness for nurses and other workers and to allow them to receive Workers Compensation disability or death benefits without employer or insurer interference when they contracted COVID.

If nurses and other front-line staff are to effectively respond to a resurgence of the virus, Infection control and PPE protocols needs to be scientifically-based and uniformly applied throughout the hospital system. In addition, nurses and other direct care providers must be involved in the design and implementation of such uniform policies and protocol. Nurses know what they need and have to be included in the process of developing uniform standards.

3. Racial and social inequalities in health outcomes and health care

We have previously noted the racial and socio-economic disparities that continue to plague our health care system and were exacerbated during the first COVID surge. Black and Latino communities in New York have long suffered lower life expectancy, higher infant and maternal mortality rates, and higher incidence of heart disease, diabetes and other chronic health conditions. People of color are more likely to be uninsured or to rely on Medicaid and other government health programs, to forego or be denied access to health care services due to discrimination, and to live in less healthy environmental conditions.

COVID made these conditions worse:

- The COVID hospitalization rate for Blacks was 711/100,000, for Latinos 685/100,000 and for whites only 320/100,000 population;
- The COVID mortality rate for Blacks was 246/100,000, for Latinos 261/100,000, and for whites only 123/100,000 population.

The shocking disparities of the COVID pandemic were made worse by the inequalities in care between safety-net hospitals and better resourced private hospitals. Blacks and Latinos were more likely to receive their care in a hospital with less funding, fewer nurses and less access to needed drugs and medical equipment.

The racial inequalities in our economic and health care system must be fully recognized and the city must take steps to address these factors before the next COVID surge.

4. Impose a moratorium on hospital closures and service reductions – particularly mental health services

The healthcare system in New York has been undergoing a sustained and intentional reduction in the number of hospitals and available in-patient beds. In New York City dozens of hospitals have closed in the last 20 years and rural hospitals are increasingly under threat of outright closure or substantial reductions in capacity and services. These closures and reductions in available services have been concentrated in low income communities and communities of color.

They also reflect an economic incentive to shed "unprofitable" services, particularly pediatrics, maternity and psychiatric hospital services. This drive has been led by the large private hospital networks, and the impact has increasingly led to a shifting of these services to the public hospitals and to private safety net hospitals.

COVID has increased the economic incentives to close or reduce unprofitable services while also giving cover to these actions in the guise of responding to the pandemic.[1] Psychiatric units, for example, are the first to be converted into "temporary" COVID patient care units.

The City of New York must take action to protect these vital services before the next COVID surge leads to yet more closures.

5. Increase City support for NYCHH and other safety net hospitals

We have already noted that the COVID crisis has disproportionately affected historically underserved communities and particularly people of color. COVID also threatens the finances and operation of these vital hospitals.

NYCHH, for example, provides services to large numbers of uninsured and Medicaid patients, for which it receives no reimbursement or is reimburse at substantially less than the cost of services. NYCHH and private safety-net hospitals, in fact, take on an increasing share of these

[1] The Greater New York Hospital Association (GNYHA) pretty openly admits that it is using the financial strains of the COVID crisis as a pretext to justify these already prevalent practices. Hospitals, says GNYHA, will have "to realign their costs" as part of "an extremely difficult process" that "may involve painful decisions for patients and communities because it will be particularly hard to preserve current service levels for clinical services that require cross-subsidization, such as obstetrics, mental health, addiction, and other services for which Medicaid is the principal funding source." Or in plain English, the hospitals want to dump the patients and services that don't generate profits.

unprofitable services and in so doing enable the profit making operations of the large private hospital networks – they shift unprofitable patients and services to the safety net hospitals and concentrate on surgical and specialty services that generate huge profits.

In this environment and with a COVID surge looming, the finances of the public and private safety-net hospitals will come under greater strain. Without direct support, NYCHH and many private hospitals will be under increasing pressure to close or substantially reduce their services, with serious impacts on the most vulnerable city communities. The City must take action to support safety-net hospitals before the next COVID surge arrives.

NYLPI

JUSTICE THROUGH COMMUNITY POWER

Testimony of Christopher Schuyler, Senior Staff Attorney
New York Lawyers for the Public Interest, Disability Justice Program
To the New York City Council, Committee on Hospitals
Oversight Hearing Examining the City's Support of NYC Hospitals During the COVID-19 Pandemic (November 5, 2020)

People with disabilities of all ages, races, genders, sexual orientations, and socioeconomic backgrounds, are among the most threatened by COVID-19. With City cases on a downward trajectory – at least for now – this is the time to correct the mistakes made earlier this year, and to improve the care given to people with disabilities, before a potentially devastating second wave hits.

I. Background

Approximately one million New Yorkers self-identify as people with disabilities.[1] In some instances, simply having a disability increases the threat of COVID-19.[2] In addition, many with disabilities have underlying conditions which are known to increase the risk of contracting COVID-19.[3] In fact, adults with disabilities are three times more likely than those without disabilities to have heart disease, stroke, diabetes, or cancer.[4] These statistics are even more troubling for Black people since 14 percent of working-age African Americans have a disability, compared with 11 percent of non-Hispanic white people.[5] Moreover, COVID-19 has been most devastating to people belonging to racial minorities, as Latino and African Americans are three times more likely to become infected than white people.[6]

[1] https://www.nychealthandhospitals.org/new-york-city-council-oversight-hearing-the-delivery-of-culturally-competent-equitable-health-care-services-in-new-york-city-hospitals/.
[2] https://www.thecity.nyc/2020/8/5/21356516/homes-for-people-with-disabilities-isolate-covid ("Emerging research suggests people with developmental disabilities are far more vulnerable to COVID-19 than the general population.").
[3] https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-disabilities.html.
[4] *Id*.
[5] https://www.nationaldisabilityinstitute.org/wp-content/uploads/2019/02/disability-race-poverty-in-america.pdf.
[6] https://www.nytimes.com/interactive/2020/07/05/us/coronavirus-latinos-africanamericans-cdc-data.html.

II. Expected Losses to Hospitals through 2021

New York State hospitals anticipate losing $25 billion through April 2021.[7] Notably, public City hospitals are already struggling – much more so than their private counterparts – and they bear most of the weight of caring for poor and working-class New Yorkers.[8] Critically, the hospital services that should be most protected are those supporting the most vulnerable populations, including people with disabilities.

III. Issues Affecting People with Disabilities Seeking Medical Care at City Hospitals During the First Wave of the COVID-19 Pandemic and Recommendations for Change

- **Threat of Rationing of Medical Care for People with Disabilities**

At the peak of the first wave, medical resource scarcity was a significant concern. Other parts of the world had already begun medical rationing.[9] And for people with disabilities, who often need higher levels of care than people without disabilities, the concern was that medical providers would make determinations to care for others less needy over them. To aid medical providers in making such determinations, New York needs clear and expansive "crisis standards of care" (CSC).[10]

Currently, New York's CSC, which was enacted in 2015, covers only the narrow issue of ventilator allocation, and does so in a way that's deeply troubling for people with disabilities.[11] Incredibly, the existing ventilator guidelines indicate that people with disabilities using a ventilator in everyday life could, when seeking acute care services during a ventilator scarcity crisis, have their ventilator removed and given to a person with a higher likelihood of survival.[12] Making a plea on behalf of people with disabilities, Disability Rights New York, the state's protection and advocacy agency, sent a letter to the Governor

[7] https://pfnyc.org/research/new-york-city-covid-19-economic-impact-update/.
[8] http://www.centernyc.org/urban-matters-2/2020/4/28/covid-19-and-hospital-inequality-why-its-getting-worse-and-how-to-fix-it.
[9] https://www.nytimes.com/2020/03/23/opinion/coronavirus-ventilators-triage-disability.html.
[10] https://www.health.ny.gov/regulations/task_force/reports_publications/docs/ventilator_guidelines.pdf (guidance on how to ethically allocate limited resources (i.e., ventilators) during a severe influenza pandemic while saving the most lives.). *See also* https://dredf.org/2020/10/15/people-with-disabilities-not-counted-in-guidance-aimed-at-equitable-allocation-of-a-covid-19-vaccine/ (Crisis standards of care around the country broadly incorporate "comorbidities" that could be used to assign lower prioritization for, or even completely exclude, COVID-19 treatment for patients with "severe or profound intellectual disabilities," "advanced untreatable neuromuscular disease . . . requiring assistance with activities of daily living or requiring chronic ventilatory support," or even just "baseline functional status," such as "loss of reserves in energy, physical ability, cognition and general health.")
[11] *Id.*
[12] https://www.thehastingscenter.org/do-new-york-states-ventilator-allocation-guidelines-place-chronic-ventilator-users-at-risk-clarification-needed/.

to redress these concerns.[13] Additionally, advocates in Kansas filed a complaint regarding that state's CSC, which were modeled after New York's, stating that "regular users of ventilators are afraid to seek medical help when they become ill because ventilator rationing may result in their every-day ventilators being re-allocated to other patients who are deemed a higher priority."[14]

New York was fortunate to avoid a ventilator rationing crisis during the first wave. However, we should not take chances. Now – before the next wave – is the time to pass updated guidelines concerning ventilator usage. The CSC need to be revised to install a clear and non-discriminatory "first come first served" approach to ventilator allocation.[15] Alternatively, given that the New York State Task Force on Life and the Law – the body responsible for the CSC – holds that people with disabilities are not at risk of having their ventilators removed, then the CSC need to be amended immediately to clarify this.[16]

Ventilators, of course, are not the only form of essential care; New York also needs to pass guidelines that assure people with disabilities that they will receive equal access to other respiratory therapies, medications, critical-care beds, and staff during a crisis. Currently, medical providers are without uniform guidance in these matters and are left in the unenviable position of making case-by-case determinations. While these determinations are supposedly "neutral" and "data driven," and intended to produce "objective, unbiased medical decisions," in practice, subjectivity about the quality of life of people with disabilities – based on bias and misinformation – plays a significant role.[17]

- **Overly Restrictive Visitor Policies**

In a frantic effort to control the spread of COVID-19 this past spring, City hospitals instituted strict no-visitor policies.[18] These policies, in some cases, negatively impacted people with disabilities, who often rely on family members, interpreters, and designated caregivers to

[13] *Id.*

[14] https://www.centerforpublicrep.org/wp-content/uploads/2020/03/Kansas-OCR-complaint-3.27.20-final.pdf. *See also* https://www.hhs.gov/sites/default/files/ocr-bulletin-3-28-20.pdf. On March 28, 2020 – one day after the advocates in Kansas filed their complaint – the Office for Civil Rights at the Department of Health and Human Services released a bulletin wherein agency Director Severino stated that "[p]ersons with disabilities…should not be put at the end of the line for health services during emergencies. Our civil rights laws protect the equal dignity of every human life from ruthless utilitarianism."

[15] https://www.nytimes.com/2020/03/23/opinion/coronavirus-ventilators-triage-disability.html.

[16] https://www.thehastingscenter.org/do-new-york-states-ventilator-allocation-guidelines-place-chronic-ventilator-users-at-risk-clarification-needed/.

[17] https://www.nejm.org/doi/10.1056/NEJMp2011359. *See also* https://www.forbes.com/sites/andrewpulrang/2020/04/14/the-disability-community-fights-deadly-discrimination-amid-the-covid-19-pandemic/#1d9206c3309c.

[18] https://thehill.com/blogs/congress-blog/healthcare/508933-people-with-disabilities-need-equal-access-to-medical-care-now.

aid in their effective communication with medical providers.[19] Without the assistance of "visitors," many people with disabilities, including those with intellectual and developmental disabilities, were unable to make informed medical decisions and were thus denied equal access to care.[20] Visitor policies need to be reconsidered, with input from stakeholder communities, to ensure that people with disabilities are not denied equal access to medical care if visitor restrictions again become necessary to control the spread of COVID-19. At a minimum, in order to ensure equal access to medical care, visitor policies need to permit a designated care person – either a family member or professional service provider knowledgeable about the needs of the patient with disabilities – to accompany that patient.[21]

- **Inadequate Communication with People who are Deaf, Hard of Hearing, or DeafBlind, as well as those needing other Language Access Assistance**

Federal, state, and local disability laws require hospitals to provide auxiliary aids and services to people with communication impairments, including those who are Deaf, hard of hearing, or are DeafBlind, thereby ensuring effective communication with medical providers.[22] Communication with people with disabilities must be as effective as communication with people without disabilities.[23] In fact, during the first wave, hospitals, overwhelmed by the crisis, often failed to provide access to American Sign Language (ASL) interpreters or even Video Remote Interpretation (VRI) via computers or smartphones. To make matters worse, masks without see-through plastic mouth portions made lip-reading impossible. These challenges, however, cannot be used as justification for a lower level of medical care.

New York Lawyers for the Public Interest (NYLPI) is aware of a case where a patient who is Deaf was denied appropriate medical care by a City hospital.[24] This person, seeking acute care, was initially denied an ASL interpreter, then denied VRI. As a last resort, this patient took out a pencil and paper, which her medical providers – unbelievably – snatched away, leaving her with no way to communicate.

[19] https://www.npr.org/2020/05/17/857531789/federal-government-asked-to-tell-hospitals-modify-visit-bans.
[20] *Id.*
[21] https://www.hhs.gov/about/news/2020/06/09/ocr-resolves-complaints-after-state-connecticut-private-hospital-safeguard-rights-persons.html.
[22] http://adapresentations.org/healthcare/doc/04-23-20/COVID19_Health_Care_and_the_ADA.pdf.
[23] *Id.*
[24] https://thehill.com/blogs/congress-blog/healthcare/508933-people-with-disabilities-need-equal-access-to-medical-care-now.

People requiring language access assistance have also reported issues which have impaired their communication with medical providers.[25] One medical provider from a City hospital stated, "[i]t takes 10 minutes of sitting on the phone to get [a foreign language] interpreter, and that's valuable time when you're inundated." The provider concluded that "the patients that are most mainstream get the best care."[26]

Hospitals need to address these shortcomings now and improve their processes for dealing with them in the future. Among other things, hospitals must ensure that there are sufficient qualified interpreters and auxiliary aids available to meet demands during a crisis, provide staff trainings on how to assess the communication needs of people who are Deaf, hard of hearing, and DeafBlind, and also remind staff of anti-discrimination policies including the obligation to provide people with disabilities with reasonable accommodations.

- **Failure to Make Exceptions to Universal Mask-Wearing Policies**

While universal mask policies are a prevailing method of controlling the spread of COVID-19, certain people with disabilities either cannot wear masks for long periods of time, or at all.[27] Disability laws ensure equal access to health care services, and when necessary, to provide accommodations, even for people with disabilities requiring conflicting accommodations.[28] Accommodations for people with disabilities who cannot wear masks include relying on telemedicine when reasonable and effective, screening and separating patients and/or visitors who may have COVID-19, and having staff use medical-grade personal protective equipment when interacting with people with disabilities who cannot wear masks.

- **Inaccessibility of Telemedicine for Certain People with Disabilities**

Telemedicine, an example of necessity driving innovation, is a valuable tool in the effort to control the spread of COVID-19. Telemedicine has experienced exponential growth since

[25] https://www.propublica.org/article/hospitals-have-left-many-covid19-patients-who-dont-speak-english-alone-confused-and-without-proper-care.
[26] *Id.*
[27] https://www.disabilityrightsca.org/post/covid-19-face-masks-and-people-with-disabilities ("Examples include individuals with developmental or intellectual disabilities, including autistic people, who cannot tolerate masks; people … who cannot independently put on or take off a mask; people with seizure disorders who may be in danger if they experience a seizure while wearing a mask (the mask may obstruct breathing or cause choking); people with lung diseases or breathing difficulties; and people with anxiety disorders who experience panic attacks while wearing masks. Some people use ventilators to support breathing, and may not be able to safely wear a face mask. In addition, some people with disabilities cannot communicate effectively with another person if the other person is wearing a mask. Examples include deaf and hard of hearing people and some people with intellectual, developmental, or processing disabilities.")
[28] https://adata.org/factsheet/health-care-and-ada.

earlier this year. Providing a snapshot of this growth, telehealth visits at NYU Langone Health and the NYU Long Island School of Medicine "jumped from 50 a day to more than 7,000 from March to April [and] ... [b]y this past August, more than 550,000 patients had been screened through a virtual platform."[29]

However, certain people with disabilities are unable to benefit from this health care option.[30] A large percentage of people with disabilities live below the poverty line; without baseline technology devices and broadband internet, the platform is not useful. Certain people with disabilities may not possess the level of technology literacy necessary to utilize telemedicine. Additionally, people with disabilities with communication impairments may not be able use the technology without the assistance of an interpreter on hand. The lack of in-person connection between the medical providers and people with disabilities risks the delivery of a lower level of care.

To address these access barriers, appropriate funding must be allocated to ensure that users possess adequate technology devices and internet services, trainings must be provided to raise technology literacy levels when appropriate, and procedures must be instituted to address the risks of diminished quality of care when treating people with disabilities through telemedicine.

IV. Recommendations

- Encourage the New York State legislature to revise its CSC pertaining to ventilator rationing, clarifying that people with disabilities currently using a ventilator will not be taken off their ventilators when seeking acute care. Additionally, broaden the CSC to assure people with disabilities that they will receive equal access to all other respiratory therapies, medications, critical-care beds, and staff during times of resource scarcity.

[29] https://mhealthintelligence.com/news/nyc-hospitals-create-blueprint-for-covid-19-triage-by-telehealth.

[30] *Id. See also* https://www.mdpi.com/1010-660X/56/9/461/htm ("The advantages of telemedicine in assessing and managing Covid-19 have been highlighted here, but when deciding whether this approach is the right one for an individual patient, it is important to consider the drawbacks. Telehealth is only possible if the patient has literacy in the modality used for delivery and if the internet or phone connection is of reasonable quality. Bandwidth, software or other technical issues may interfere with data transmission and obstruct visual and/or auditory aspects of communication. This problem may be encountered more commonly in rural areas and in socioeconomic disadvantaged environments with limited access to technology. Privacy and confidentiality may also be an issue for patients using equipment in areas frequented by other household members. Use of headphones by the patient may be helpful, but do not guarantee privacy. Persons with barriers to use of technology such as visual or hearing impairments may require in-person visits, although specialized communication platforms can make telecare feasible in some circumstances. Without the in-person encounter, the feeling of a personal connection and establishment of a provider-patient relationship with the key elements of trust and mutual respect is more difficult.")

- Revise City hospital visitor restriction guidelines, with input from disability community stakeholders, to ensure the rights of people with disabilities to equal access to medical care.

- Mandate training for medical providers at City hospitals to recognize implicit bias as it pertains to people with disabilities. Unacknowledged bias has been demonstrated to contribute to worse health outcomes for people with disabilities.[31]

- Encourage the New York State legislature to repeal Article 30-D of the Public Health Law, also known as the Emergency or Disaster Treatment Protection Act, which offers broad protections to hospitals and their executive leadership from civil liability arising from certain acts or omissions resulting in harm during the COVID-19 pandemic, thereby stripping patients and family members of their rights to hold hospitals accountable.

- Allocate appropriate funding and resources to improving the telehealth experience for people with disabilities.

Thank you for the opportunity to testify about the key issues which have negatively impacted access to medical care for people with disabilities during the COVID-19 pandemic. Please feel free to contact me to discuss further.

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About New York Lawyers for the Public Interest
For over 40 years, NYLPI has been a leading civil rights and legal services advocate for New Yorkers marginalized by race, poverty, disability, and immigration status. Through our community lawyering model,

[31] Independence Care System & New York Lawyers for the Public Interest, Breaking down barriers, breaking the silence: Making health care accessible for women with disabilities (2012), p. 7, 15. Available at: https://www.nylpi.org/images/FE/chain234siteType8/site203/client/breakingbarriers.pdf. *See also* ADA National Network, Health Care Access and the ADA: An ADA Knowledge Translation Center Research Brief (2019). Available at: https://adata.org/publication/health-care-access-and-ada *citing* Yee, S., et al., Compounded disparities: Health equity at the intersection of disability, race, and ethnicity, The National Academies of Sciences, Engineering, and Medicine (2016).

we bridge the gap between traditional civil legal services and civil rights, building strength and capacity for both individual solutions and long-term impact. Our work integrates the power of individual representation, impact litigation, organizing, and policy campaigns. Guided by the priorities of our communities, we strive to achieve equality of opportunity and self-determination for people with disabilities, create equal access to health care, ensure immigrant opportunity, secure environmental justice for low-income communities of color, and strengthen local nonprofits.

NYLPI's Disability Justice Program

NYLPI has a long history of fighting for the rights of people with disabilities, including in the area of access to medical care. As a member of a coalition of advocates and City and State civil rights enforcement agencies, NYLPI pursues systemic improvements by connecting with community members to educate them about their rights to accessible medical equipment, accessible facilities, reasonable accommodations, and filing complaints. During the COVID-19 pandemic, NYLPI has reminded various of the large City hospitals of their obligations to provide auxiliary devices and services for people who are Deaf, hard-of-hearing, or Deafblind.

Community Health Care Association of New York State Written Testimony
NYC Council Committee on Hospitals, Committee on Oversight & Investigations
Examining the City's Support of NYC Hospitals During the COVID-19 Pandemic
November 4, 2020

The Community Health Care Association of New York State (CHCANYS) thanks the NYC Council for its continued attention to critical issues surrounding the response to the novel coronavirus (COVID-19) pandemic, including the support received by hospitals and community health centers throughout pandemic response. CHCANYS represents New York State's federally qualified health centers, also known as community health centers (CHCs). We submit this written testimony on behalf of our members' 459 New York City CHC sites, and the more than 1.3 million patients served at those locations annually.

CHCs are the front-line defense against preventable illness, especially during the pandemic. Our members' robust and widespread network of CHCs throughout the City have continued to provide comprehensive primary and follow up care to City residents, regardless of insurance status, immigration status, or ability to pay. Our CHCs are located in medically underserved communities and oftentimes are the only source of primary care for low income New Yorkers. In NYC, 14% of CHC patients are uninsured, 62% are enrolled in Medicaid or CHIP, 75% identify as Black, Hispanic, or Latinx, and 30% are best served in a language other than English. The communities we serve are among the hardest hit by COVID-19 and are overrepresented due to the disproportionate effect that the virus has had on communities of color.

CHCANYS is thankful for the close partnership and collaboration with the NYC Council, NYC Emergency Management, the Department of Health and Mental Hygiene and Health + Hospitals during COVID-19 response to date. Previously, we testified about the following hurdles to meeting our highest potential in combating COVID-19. We are happy to share an update on progress in two key areas:

1. ***Guidance Limiting CHCs as Testing Sites Reversed.*** We previously testified that DOHMH guidance[1] inhibited CHCs' ability to test outpatients for COVID-19, despite the City and State public policy of making tests widely available for all New Yorkers. DOHMH has since reversed the guidance and removed the unjustified barrier to testing at CHCs. CHCs across the City are testing patients for COVID-19. Additionally, many CHCs continue to partner with Health + Hospitals in their COVID-19 testing and contract tracing program.

2. ***CHC Priority Access to PPE***. NYC Emergency Management did not initially designate CHCs as priority providers to receive PPE in pandemic response. This inhibited CHCs' ability to remain open for in-person care. Emergency Management must recognize the role that our members play in COVID-19 response, particularly in an attempt to divert patients from unnecessarily presenting in emergency rooms. In contrast, DOHMH has committed to providing PPE to CHCs in the event of a second surge. It will be imperative for the City to keep its promise and ensure CHCs have access to PPE to remain open. If CHCs are not open to provide in-person primary and preventive care,

[1] https://www1.nyc.gov/assets/doh/downloads/pdf/han/advisory/2020/covid-19-03202020.pdf

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New Yorkers may experience higher complications due to chronic disease and other associated illnesses, leading to hospitalization.

CHCs continue to have significant needs in the area of reimbursement and capital investment:

1. ***Sustained reimbursement for robust telehealth.*** There continues to be a lack of certainty around reimbursement for CHC services delivered remotely – in particular, for audio-only services. This uncertainty continues to inhibit long term planning and implementation of comprehensive remote care workflows at CHCs. Without telehealth, many CHC patients may have been forced to visit the overwhelmed hospitals for minor illness that could have been solved via a remote visit.

2. ***Capital investment for redesign of CHCs.*** Our CHC members still need to redesign physical spaces to ensure appropriate social distancing and mitigate potential spread of COVID-19. Capital investment is needed to create separate and distinct screening and testing locations, remodeling waiting rooms and renovating HVAC systems for proper air filtration.

CHCs serve as the front-line defense against preventable inpatient hospitalization and emergency room visits. To ensure hospitals are not overwhelmed in a second surge, CHCs need to be included as a vital partner in planning and developing comprehensive responses to the ongoing pandemic. We look forward to continued discussions with the NYC Council, the city's hospital systems, and the Department of Health and Mental Hygiene on ways to ensure all New Yorkers have access to timely, comprehensive primary care. For questions or follow up, please email Marie Mongeon, Director of Policy at mmongeon@chcanys.org.

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Testimony for the New York City Council Committee on Hospitals: Oversight - Examining the City's Support of NYC Hospitals During the COVID-19 Pandemic

November 5, 2020

It is often said that what gets measured gets done, but the opposite is also true and what is prioritized or valued for measuring success or effective response can ignore and sustain inequities. New York State and New York City need to understand where their preparedness gaps are to rectify them to better prevent future outbreaks from evolving into worse outcomes. The COVID-19 pandemic has brought about new challenges for health care facilities including the way or lack of ways they work together and communicate. While pandemics are not random events, outbreaks of well-known infections and new diseases occur regularly. COVID19 has been the ultimate stress test for our health care and public health systems, city interagency efforts, our communities, and this nation. But It is not premature, however, to ask what went wrong early with New York coordination communication and response to the pandemic. What can be done to ensure that New York can be better prepared when the next one strikes and more urgently now with slight rise of hospitalization and localized outbreaks. To better prepare for the next crisis, and future waves of the current one, New York will need to devote considerable political capital and economic resources to reducing the vulnerabilities that jeopardize individuals and families, especially BIPOC and other marginalized communities.

In the past 8 months, COVID-19 has upended our lives to an extent few imagined. The virus has already infected over twenty-five million people around the world, killing over 846,000, numbers that almost certainly underestimate the extent of the toll. And they will continue to mount. (over 500k infected and over 30,000 deaths in NYC)

Current and historical experiences in New York is necessary for the understanding on what we can do to improve and have an assessment of the City's support. The national, state and local dimensions of the pandemic are mutually reinforcing and cannot be considered in isolation." In the short run, we need calls for establishing a framework to ensure equitable process and implementation plan. These are some of the factors and experiences that were mutually reinforcing:

Devastating Historical issues:

- Inadequate investment in state and local health systems, many of which were quickly overwhelmed.
- Institutional and structural racism
- Risks of overdependence by the state on a single set of or favored Hospital leadership (i.e. Northwell) to advise and develop plans and reports, especially around disproportionate impact on communities of color.
- Societal, political, and governmental narratives continue to have toxic effects on a advancing a more equitable approach and rewriting of history in defense of corporate and hospital interests, and state Health Department. The newest narrative or "spin" has come from the Governor when he recently stated that New York's hospitals "were never overwhelmed" at the peak of the COVID-19 pandemic. He added "We always had excess capacity in hospitals, we always had excess capacity in emergency hospitals that we built. So, we were never in a situation where we had to have a nursing home accept a COVID-positive person."
- Since November 2016, New York's health system cut thousands of hospital beds in search of cost savings and efficiencies over the prior decade. The problem was the Commission on Health Care Facilities in the 21st Century, also known as the Berger Commission, and Hospital Closing Commission -a governmental effort that contributed to hospital closures and a 20% reduction in beds statewide impacting disproportionately the uninsured, BIPOC, and immigrants- documented and undocumented
- Since 2003, New York has seen 41 hospitals closed statewide, including 18 in New York City alone.
- 12 big hospital systems now control 70% of the acute care beds in NYS. So, control of all these hospital beds that we needed early on in this pandemic have come into the hands of just a dozen health systems. The ones in NYC Northwell, Mount Sinai, Montefiore NYU Langone are the big players. They have outsized role in determining the future of hospitals in NY.

Serious Situational issues

- Health outcomes have been considerably worse for those older than sixty-five and with comorbidities such as diabetes and chronic kidney diseases, but the virus has also spread disproportionately among marginalized communities who are inadequately served by New York's. health-care system and lack sufficient social protections.
- Blacks and Latinx are overrepresented in COVID-19 Deaths
- Transmission rates have been higher among workers designated as essential, including those in health care, food service, and public transportation, as well as those with crowded living and working conditions for whom social distancing is not possible.
- More broadly, nursing homes, prisons, meatpacking plants, homeless shelters, and psychiatric or developmental care facilities represent nearly all the largest clusters of COVID-that occurred between January and May 2020.
- Access issues, social determinant of health, and behavioral dimensions of testing including language access issues.
- Deployment of contact tracers were problematic. Optum as a contractor for COVID-19 Test and Trace informatics and operations. The use of a private contractor also leads to delays in the ability of city officials to access and assess Test and Trace data, and the ability of the city to share these data with the public. All for-profit companies have inherent primary fiduciary responsibility to owners and shareholders and not to the ostensible mission nor to the community or to public health. Being part of an insurance company, Optum has an inherent conflict of interest in its relationship with all other stakeholders in health and health care.
- The failure to maintain an adequate Strategic National Stockpile (SNS)—and to clarify the rules governing its use—led to shortages of essential medical supplies and competition among states over scarce medical equipment.
- Lack of a multilateral mechanism to encourage the joint development and local equitable distribution of PPE's.
- COVID-19 revealed tremendous confusion over the respective responsibilities of federal, state, local, and tribal governments, resulting in blame-shifting, inflated egos of both our state and city executive leadership and an incoherent approach to this public health emergency.
- Experience with influenza pandemics indicates that people generally can accept personal protective measures at the beginning of the pandemic. However, as more people become ill, patience for doing these measures wanes. To slow the spread of the virus, the goal to keep the public engaged and encourage cooperation has been challenging.
- We had made matters worse if we use police to enforce any distancing rules. Early efforts by New York City Mayor de Blasio and Governor Cuomo to shift responsibility of social

distancing away from government-supported public health education and instead onto individual efforts via increased policing and increased fines.

- limitations of existing national and global systems of epidemic threat surveillance and assessment, which left public health officials and researchers without access to timely data.
- Only 134 of the 1,000 beds at the Javits Center were full and the Comfort — it was reconfigured to treat up to 500 COVID-19 patients — treated fewer than 200 patients.
- At least 6,300 COVID-19 patients were transferred from hospitals into nursing homes,
- The Army Corps of Engineers had contracted with private companies to turn convention centers and other sites into emergency field hospitals. Federal spending totaled more than $660 million for NY $11,364,953 and capacity was for 1,900 beds but only 1,095 beds or less were utilized.
- New York State DOH allowed Mount Sinai to work with Samaritan Purse, a private vendor to run a field hospital with clear hatred for LGBTQ+ community.
- Competitive private enterprise model became glaringly apparent during the height of the first round of the pandemic, as safety net hospitals serving poorer communities were flooded with COVID patients while nearby hospitals remained underutilized. The disparate distribution of necessary medications supplies, and personal protective equipment led hospitals to desperately scramble to locate supplies on domestic and foreign markets. The richer hospitals were able to use their connections and cash reserves to secure what they needed while safety net hospitals were forced to conserve equipment and supplies to the detriment of staff and patients.
- Without further disaggregation of data on our neighborhoods and communities, we cannot effectively identify where the problems exist deeper than zip code, nor can we properly allocate the limited resources available to minimize that harm.
- Engagement of community-based and faith-based organization was slow and still at times sporadic, episodic, reactive, and not fully encompassing of voices and expertise including in the T2 contracting of organizations.
- Ventilators were in short supply but so were dialysis machines.
- Nurses were being trained to provide care in fields where they have limited experience. Hospitals had scaled back services to ensure enough staff to handle critically ill patients. And health systems turned to short-term travel nurses to help fill the gaps.
- Contracting outside vendor that lacks cultural competency to do the hiring of the tracers

We do want to commend the city for the following tactics that provided indirectly some support to hospitals:

- Creation of the T2 Community Advisory Board as a mechanism for community-based and faith-based organizations engagement in the test, trace and take care process and response to the pandemic.
- Contracting of community-based organizations to do navigation, community outreach and engagement and public health education.
- Advocacy for utilization of resources and funding stream to ensure NYC Health+ Hospitals can continue protecting and taking care of All New Yorkers, especially low-income, immigrant, and communities of color. The unique reach and capacity of the NYC Health + Hospitals may have played a role in saving the lives of low-income, Medicaid enrollees and uninsured that depend on it.
- Returning responsible of social -distancing and other public health measures to public from the police to health professional and agencies (at least at most part done)
- Expanding open streets program and permanent sidewalk permits for restaurant and bars, which has helped flatten the curve and stressors that hospitals felt.
- Use of hotels for isolation and quarantine efforts

We know that the city has limitation in their role or jurisdiction of hospitals. This is primary responsibility of the state. However, the following could be addressed by the city to strengthen the three fundamental elements of pandemic, which are preparedness: prevention, detection, and response. They are:

Strengthen Pandemic Elements

- Develop a comprehensive public health plan around COVID response that will address problems of cultural competency, equity, and institutional oversight. This would include preparedness capacity assessments and pair them with strategies to promote readiness and implementation. The objective should be to generate community mitigation guidelines and pandemic response triggers so that local policymakers have a roadmap for early, targeted, and coordinated implementation of surveillance, non-medical interventions, holistic and mutual aid approaches, and measures to reinforce medical and public health capacities.
- Establish and enforcing pandemic readiness standards for hospitals and health systems and ensuring that these institutions respect and promote health equity.
- Make it standard practice to collect and share data on the risk of specific communities, most notably Black, Native Americans, Latinx, low-income families, and the elderly, to pandemic disease.
- Craft strategies, programs, budgets, and plans for targeted public health investments that increase the resilience of marginalized communities. Efforts cost money. relative to the

economic and health risk. Therefore, we recommend adoption of an equity assessment with the city budget on what is provided as support to hospitals. This equity assessment should be expanded to every part of the city budget process. They are examples across the nation related to this concept. Racially inequitable policies and budget decisions should be defined as any that result in inequitable outcomes by race, regardless of any indications of racial bias. Integrate explicit consideration of racial equity into the operations of NY government should start with a baseline assessment of major health policies and programs across NY government.

- Equity assessments are conducted by an independent entity —ideally by an organization with deep experience in understanding inequity— rather than the NYS government itself, to ensure unique observations and limit any bias toward not exposing racially inequitable policies.
- A full assessment of racial (would expand it to other groupings) inequity also should include extensive community engagement (which we know would be a push back)
- Keep informed on any challenges with hospitals and the Comprehensive Hospital Preparedness Checklist for Coronavirus Disease 2019 (COVID-19). Hospitals are required to report the detailed information to federal and state. In his case the State certified themselves to collect the data from the hospitals and take over some of the hospital's federal reporting responsibilities.

Be bold with the powers or tools of city government

- Ensure the Board of Health declares Racisms and Public Health Crisis. Last time Board of Health met was 9/15. They should pick up the ball again on this referendum
- Vigorously exercise the jurisdiction of the Commissioner of the New York City Department of Health and Mental Hygiene and leader of the NYC Board of Health in setting a comprehensive public health agenda for controlling the COVID-19 pandemic. Along with NY Docs, a broad coalition of New York City health care workers, activists, public health experts and concerned citizens, we seek your partnership and leadership in response to the vast inequities in COVID-19 infection and death across racial and ethnic groups and zip codes in NYC.
- Pending Governor Cuomo's signing of the Rivera Gottfried S8450/A10500 bill to ensure that contact tracing data is not shared with law enforcement and ICE, the City must be prepared to pass its own confidentiality legislation.
- Develop and find resources for a Health impact assessment Tool for COVID Equity Metric-like but more improved than what California is implementing (i.e. beds per thousand and other hospital metrics)

- Create COVID Clinics like the creation of the World Trade Center Clinic and expand on idea of the Center of Excellence model for COVID19 that is being developed by H+H. Those who survived COVID are still susceptible and having differential health outcomes and treatment. They are showing cardiac, renal, and respiratory complication event after no longer having COVID-19. This should have a direct link to research and development of common practices for standards of care.
- Ensure PPE applications require training and annual updates like what is done for Ebola.
- Expand the role of the public and local government in the Certificate of Need regulatory process: In keeping with the market oriented structure of the health care system, the current certificate of need process allows private hospitals and other providers to make their own self-interested decisions to expand or reduce services and then to seek out approval with little or no public input or consideration of the broader needs of local communities. The CON process must be revamped to require a more critical showing of local needs (both for new services driven by revenue projections of the provider and for reductions or elimination of services that don't generate revenues even though they may be needed in the community). Require by state law public hearings in the affected communities when CON's are submitted and increase the number of community/patient representatives on the Public Health & Health Planning Council (PHHPC).
  Further disaggregate existing data collection around race/ethnicity, sex, and age. Expand this to include collecting information on primary written and spoken language, disability status, sexual orientation, gender, identity, and socioeconomic status of participants. Hospitalization and other data sets required for hospitals to submit should be further disaggregated, more accessible, and allow for greater flexibility in analysis. Furthermore, this data should be disaggregated by ethnicity. Local Law 126 requires City agencies to collect disaggregated data by ethnicity by providing the top 30 largest ancestry groups and languages spoken in the city of New York based on Census data, plus a write in option, however, does not extend to the Health and Hospitals Corporation. Data are also vital to understand inequities in society, to explore how these inequities influence health and well-being, and to inform and evaluate interventions to build a stronger and more equitable society. Generating necessary evidence requires both new areas of inquiry as well as the capacity to better disaggregate data to understand different experiences.

Support for our largest Safety-net Provider- NYC Health+ Hospitals and other safety-net facilities

- Create a plan to shift the test and tracing efforts back to NYC Department of Health and Mental Hygiene. NYC Health + Hospitals is already financially burdened and added pressures and responsibility without any access to sufficient funding can create and perhaps create a financial strain on the public hospital system.
- Immediate shift away from Optum as a contractor for COVID-19 Test and Trace

informatics and operations.

- Shift resources and funding given the police to public health and investment into our public hospital system. The city was not genuine in the effort to truly make this a reality. Instead it was a "shell game".
- Stronger and more vocal advocacy to the state on the following:
    - Equal funding for NY H+H, safety net hospitals and other care givers, and expansion of direct care and support services to target low-income, marginalized patients and communities. Increase reimbursement rates for underfunded safety net hospital and services. we have a general inequality in hospital funding caused by structural distortions in reimbursement rates between Medicaid, Medicare and other government sponsored health care on the one hand, and private insurers on the other.
    - Formulas for the distribution of ICP funding should be restructured and those funds should be target exclusively to safety net hospitals, and particularly to hospitals that meet the statutory definition of Enhanced Safety Net Hospitals under PHL Section 2807-c (34). Some hospitals receive ICP funds even though they provide very few services to Medicaid patients. In addition, many large network hospitals that routinely generate extremely high net revenues (profits) because they have high rates of privately insured patients continue to receive ICP payments that they do not need.
    - A moratorium on hospital closures and service reductions. The healthcare system in New York has been undergoing a sustained and intentional reduction in the number of hospitals and available in-patient beds. In New York City dozens of hospitals have closed in the last 20 years.
    - Passage of The New York Health Act
    - Development of coordinated purchasing pools based on local needs and not institutional interest and competition.

- Medicare diagnostic code specifically for COVID-19.
- The need for minimum staffing standards and ratios. The conversion of space and the procurement of beds and ventilators was accomplished relatively easily. What was not easy to accomplish, however, was to find adequately trained staff to provide care for the expanded admissions of COVID patients. Improved staffing standards will lead to better care under normal circumstances and will improve the capacity of hospitals to respond to COVID and other public health emergencies. The state must implement minimum standards and protocols to require that hospitals meet minimum

- Effectively coordinate and direct patient care within the hospital system, including the proper distribution of PPE to protect staff.

City can assist hospitals with strategies for pre-pandemic investments in holistic approaches to health, cross-sector collaborations, investments in data systems, and actions to promote health equity are key. We must address the value of a community's interest and focus on health and well-being before COVID-19; Role of cross-sector collaborations for health and well-being in responses to the pandemic; Use of data and systems to effectively monitor and track the course of the disease; and Role of a community's perspective on and actions to address health equity and meet the needs of historically underserved populations. Relevant and accurate data are required to effectively develop, implement, and evaluate public health measures to control the pandemic and recover afterwards.

Thank you to Councilwoman Carlina Rivera, Chair of and City Council members of the Hospital Committee for the opportunity to testify.

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Testimony of the Community Service Society of NY Before the New York City Council's Hearing, *Oversight: Examining the City's Support of NYC Hospitals During the COVID-19 Pandemic*

October 26, 2020

The Community Service Society of New York (CSS) would like to thank the Committee on Hospitals and the Committee on Oversight & Investigations for holding this hearing.

CSS is a 175-year-old non-profit organization dedicated to achieving equity by improving the lives of low-income, working New Yorkers. Our health programs help New Yorkers enroll into health insurance coverage, find healthcare if they are ineligible or cannot afford coverage, help them use their coverage, or otherwise access the healthcare system. We do this through a live-answer helpline and in partnership with community-based organizations. Annually, CSS and our CBO partners serve approximately 130,000 New Yorkers in multiple languages.

CSS would like to begin its testimony on the important topic of the COVID-19 pandemic and New York's hospitals by saluting the incredible dedication of the staff who work in our hospitals and the broader healthcare system. Nurses, orderlies, technicians, physicians, and administrators have worked tirelessly and selflessly—often at enormous personal peril— to care for their patients and their communities in the face of this highly infectious and devastating pandemic. We are grateful for and saddened by the sacrifice of so many front-line workers.[1]

The remainder of this testimony will focus on the dramatically disparate impact the COVID-19 pandemic has had on communities of color in comparison to white communities—and the policies in New York's hospital financing and planning structure that contributed to these disparities. This issue is described in our June 2020 report, *How Structural Inequalities in New York's Health Care System Exacerbate Health Disparities During the COVID-19 Pandemic: A Call for Equitable Reform*.

[1] *See* Kaiser Health News & The Guardian, "Lost on the Frontline," documenting nearly 1,000 medical worker deaths in the United States due to the COVID-19 pandemic, October 21, 2020, available at: https://khn.org/news/lost-on-the-frontline-health-care-worker-death-toll-covid19-coronavirus/

The Disparate Impact of COVID-19 on Communities of Color is Socially Constructed

It is well-settled that the COVID-19 pandemic has a disparate impact on people of color in New York City. The death rate for African American and Latinx New Yorkers is twice that of white people (267 and 250 compared to 125 per 100,000). Both groups also are more likely have a COVID case and be hospitalized with COVID.[2]

Age-Adjusted Rate of COVID-19 Cases per 100,000 in New York City			
Race/Ethnicity	**Cases**	**Hospitalizations**	**Deaths**
Hispanic/Latino	2,063	730	**267**
Black/African-American	1,870	731	**250**
Asian/Pacific Islander	848	287	112
White	1,314	339	125

Source: New York City Department of Health, October 20, 2020

The medical literature has documented the pervasive nature of racial and ethnic health disparities long before the pandemic and reiterates that there is no genetic or biologic basis for them.[3] Rather, these disparities are social constructions. For example, many people of color work and live in environments that are injurious to their health and impose higher risks of exposure to COVID-19.[4] In New York City, more than 75 percent of essential and front-line workers are people of color.[5] Not only do many of these "essential" jobs have a higher risk of viral exposure but they often lack essential supports such as comprehensive health coverage.[6]

These social determinants of health are major drivers of the substantial racial disparities observed during the COVID-19 pandemic. ***But it is also important to recognize that before the pandemic, many people of color were already experiencing significant health disparities and relied on an under-resourced health care system.***

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[2] New York City Department of Health, https://www1.nyc.gov/site/doh/covid/covid-19-data.page.

[3] C.W. Yancy and A.J. Kitane, "Race/ethnicity-based outcomes in cardiovascular medicine," JAMA, 2(2017), pp. 1313-1314, https://jamanetwork.com/journals/jamacardiology/article-abstract/2657545; Jason Silverstein, "Genes Don't Cause Racial-Health Disparities, Society Does," The Atlantic, April 13, 2015, https://www.theatlantic.com/health/archive/2015/04/genes-dont-cause-racial-health-disparities-society-does/389637/.

[4] R.R. Habib et al., "Housing quality and ill health in a disadvantaged urban community," Public Health, Feb. 2009: 174-81, doi: 10.1016/j.puhe.2008.11.2002. J. Valasquez et al., "COVID sends Public Housing-Zone Residents to Hospitals at Unusually High Rates," The City, May 15, 2020. NYU Furman Center, "State of New York City's Housing and Neighborhoods in 2017," https://furmancenter.org/files/sotc/SOC_2017_Full_2018-08-01.pdf.

[5] Yoav Gonen, Ann Choi, and Josefa Velasquez, "NYC Blacks and Hispanics Dying of COVID-19 at Twice the Rate of Whites, Asians," The City, April 8, 2020, https://thecity.nyc/2020/04/nyc-blacks-and-hispanics-dying-of-covid-19-at-twice-the-rate.html.

[6] Whitney L. Duncan and Sarah B. Horton, "Serious Challenges and Potential Solutions For Immigrant Health During COVID-19," Health Affairs blog, April 18, 2020, DOI: 10.1377/hblog20200416.887086; "Excluded in the Epicenter: Impacts of the COVID Crisis on Working-Class Immigrant, Black, and Brown New Yorkers," May 2020, Make the Road New York, https://maketheroadny.org/wp-ontent/uploads/2020/05/MRNY_SurveyReport_small.pdf; James A. Parrott and Lina Moe, "The New Strain of Inequality: The Economic Impact of COVID-19 in New York City," The New School Center for New York City Affairs, April 15, 2020; https://static1.squarespace.com/static/53ee4f0be4b015b9c3690d84/t/5e974be17687ca34b7517c08/1586973668757/NNewStrainofInequality_April152020.pdf.

The remainder of this testimony outlines how these structural deficits in New York's health care system have exacerbated the impact of the COVID-19 pandemic on low-income communities of color.

Disparities in Hospitals and Healthcare Services for Communities of Color

Policy decisions regarding the planning and financing of health care resources in New York have favor wealthier neighborhoods.[7] In the 1990s, New York eliminated its all payer rate regulation system that had ensured that safety-net hospitals had adequate financial support to survive.[8] During the same period the state also eviscerated New York's strong tradition of statewide health planning by eliminating its regional Health Systems Agencies.[9] As a result, since 2003, 43 hospitals have closed around New York State, dropping the number of beds statewide from almost 74,000 in 2000 to just 53,000 in 2020.These hospital closures mostly occurred in poor neighborhoods where there were fewer patients who could pay – not fewer patients.[10] They are also the neighborhoods where more patients are falling ill and dying from COVID-19.

The result of these policies is displayed in the below, in New York City, Manhattan, which only has 21 COVID-19 cases per 1,000 residents, has 6.4 hospital beds per resident. In the Bronx, with a COVID-19 rate almost twice as high, there are only 2.7 hospital beds for every 1,000 residents. Queens has the biggest population of the five boroughs and a high rate of COVID-19 cases – but has the least hospital beds at only 1.5 per 1,000 residents.

Hospital Beds Compared to COVID-19 Cases in New York City's Five Boroughs		
Borough	**Beds per 1,000 People**	**COVID-19 Cases per 1,000 People (as of 11/4)**
Bronx	2.7	39
Brooklyn	2.2	29
Manhattan	6.4	21
Queens	1. 5	34
Staten Island	2.5	36

[7] David Robinson, April 10, 2020, LoHud/USA Today, "Why NY hospital closures, cutbacks made COVID-19 pandemic worse," https://www.recordonline.com/news/20200410/why-ny-hospital-closures-cutbacks-made-covid-19-pandemic-worse. C. Campanile, "New York Has Thrown Away 20,000 Beds, Complicating Coronavirus Fight," New York Post, March 17, 2020, https://nypost.com/2020/03/17/new-york-has-thrown-away-20000-hospital-beds-complicating-coronavirus-fight/.

[8] Sharon Shallit, Steven Fass, and Mark Nowak, "Out of the Frying Pan: New York City Hospitals in the Era of Deregulation," Health Affairs, January 2002, https://www.healthaffairs.org/doi/full/10.1377/hlthaff.21.1.127.

[9] Health Planning In New York State—History and Present Activities, May 2012, https://www.health.ny.gov/facilities/public_health_and_health_planning_council/meetings/2012-03-21/docs/health_planning_in_nys.

[10] Lena Afridi and Chris Walters, "Land Use Decisions Have Life and Death Consequences," Association for Neighborhood & Housing Development, April 10, 2020, https://anhd.org/blog/land-use-decisions-have-life-and-death-consequences.

Areas with high COVID-19 burdens already had higher disease burdens than others before the pandemic– so why are they the areas with the least healthcare infrastructure?

Government funding for New York's hospitals is not allocated through rigorous health planning that takes community need into account. All hospitals in New York are non-profits that pay no taxes and receive billions of dollars in federal and state support every year. New York City's property tax expenditure is estimated to be as much as $640 million for 38 non-profit hospitals.[11] Yet some hospitals behave more charitably than others in their medical collections practices and in their service provision.[12] The Lown Institute inclusivity measure describes how closely a hospital's patient mix matches the population in its service area using data on race and income.[13]

The allocation of New York's $1.1 billion Indigent Care Pool is an important example of structural policy decisions that result in profound disparities in communities of color and the safety-net hospitals that serve them. Hospitals receive this funding even when they fail to provide patients with financial assistance.[14] Many hospitals receive more indigent care pool funding than they provide in financial assistance to patients. These same hospitals also make it difficult for patients to learn about and apply for the financial assistance they are legally required to offer.[15]

Other states target these funds to safety-net hospitals, which are defined to be the top quartile of hospitals in a state that serve Medicaid and uninsured patients.[16] Instead, New York only apportioned $520 million (or 46%) of the $1.13 billion ICP funds to the top 25 percent of safety-net hospitals and $672 million to the bottom 75 percent of hospitals that do not serve nearly as many low-income people.[17] Taken over the past 20 years, New York's choice to direct over half of its ICP allocation to hospitals that do not serve a substantial number of Medicaid and uninsured patients has meant its safety-net hospitals received roughly $13.4 billion less in funding than they would have if they had been located in any other state in the country.

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[11] Geoffrey Propheter, "Property Tax Exemptions for Nonprofit Hospitals: What Are They Worth? Do They Earn Them? Evidence from New York City," Public Budgeting & Finance, Summer 2019.
[12] A. Dunker and E. Benjamin, "Discharged into Debt: New York's Hospitals Are Suing Patients," Community Service Society, March 2020.
[13] Saini, V., Chalmers, K., Brownlee, S., Garber, J. Measures of Inclusivity at Hospitals in the United States. Brookline, MA: The Lown Institute. 2020.DOI: https://doi.org/10.46241/LI.FKAL3278
[14] Carrie Tracy, Elisabeth Benjamin, and Amanda Dunker, "Unintended Consequences: How New York State Patients and Safety-Net Hospitals Are Shortchanged," Community Service Society of New York, January 2018, https://nyshealthfoundation.org/wp-content/uploads/2018/01/new-york-state-patients-safety-net-hospitals-jan-2018.pdf.
[15] E. Benjamin, A. Garza and C. Tracy, "Incentivizing Hospital Financial Assistance: How to Fix New York's Indigent Care Pool Program, Community Service Society, January 2012.
[16] J.P. Sutton et al., "Statistical Brief #213: Characteristics of Safety-Net Hospitals, 2014," Healthcare Cost and Utilization Project, Agency for Healthcare Research and Quality, October 2016.
[17] New York State Department of Health, 2018 Hospital Institutional Cost Reports and 2016 Hospital Inpatient Discharges (SPARCS de-identified), Bureau of Health Informatics, Office of Patient Quality and Patient Safety, New York State Department of Health.

Federal COVID-19 financing has only exacerbated these disparities. The initial distributions of the Provider Relief Fund created by the federal Coronavirus Aid, Relief, and Economic Security (CARES) were based on the provider's revenue in 2018 – a formula guaranteed to short-change safety-net providers that serve low-income patients.[18] Additional funding waves attempted—but failed—to address this initial inequity.

New York City's public Health and Hospitals Corporation received the highest total payment ($1.2 billion). But that was for all 11 of its hospitals, which is just about $106 million per hospital. By contrast, many well-heeled private and voluntary hospitals received much more than $106 million for individual facilities. For example, New York University shows up twice in the top 30 payments – for NYU Langone it received $427 million, and it received an additional $109 million as New York University. New York Presbyterian's $631 million payment covers at most 4 facilities, meaning it received at least $160 million per hospital. Presbyterian appears three times in the 30 highest payments. Besides the $631 million, it received another $160 million for its Queens hospital and another $121 million for its Brooklyn hospital.

Ten Highest Provider Relief CARES Act Payments to New York Providers, as of October 23, 2020

Hospital	Payment
NYC Health and Hospitals Corporation ($106 million per hospital)	$1,167,000,000
The New York and Presbyterian Hospital	$631,000,000
Montefiore Medical Center	$468,000,000
NYU Langone Hospitals	$427,000,000
Long Island Jewish Medical Center	$409,000,000
Mount Sinai	$282,000,000
North Shore University Hospital	$219,000,000
Maimonides	$227,000,000
St. Lukes Roosevelt Hospital Center	$185,000,000
Beth Israel Medical Center	$171,000,000

Providers in Manhattan received almost five times as much relief funding per case as those in the Bronx.[19] Residents from all over New York City seek care in Manhattan, so it is expected that providers there would treat more patients for COVID-19 than just the residents of Manhattan who tested positive. However, fatalities are reported by place of death – so relief funding per fatality reflects the burden experienced by the providers. Using that metric, providers in Manhattan received three times more relief funding than those in the Bronx– and twice as much as those in Staten Island, whose providers received the next highest payments.

[18] United States Department of Health and Human Services, "CARES Act Provider Relief Fund Frequently Asked Questions," available at https://www.hhs.gov/sites/default/files/provider-relief-fund-general-distribution-faqs.pdf.
[19] After redistributing Health & Hospitals' total payment across the boroughs according to where their hospitals are located.

Borough	Beds per 1,000 People	COVID-19 Cases per 1,000 People	CARES Act Relief Funding per Positive Test	Relief Funding per COVID-19 Death
Manhattan	6.4	21	$62,000	$667,000
Bronx	2.7	39	$13,000	$237,000
Brooklyn	2.2	29	$18,000	$294,000
Queens	1.5	34	$12,000	$222,000
Staten Island	2.5	36	$15,000	$346,000
Citywide		**31**	**$21,000**	**$347,000**

Policies like this established nearly insurmountable structural inequities in our healthcare system. As a result, the hospitals that anchor care in low-income communities of color that suffer the most from COVID-19 were already under-resourced, even before the pandemic. The result has been devastating for those communities. Patients at well-resourced hospitals in Manhattan have had significantly higher survival rates than those at safety-net hospitals that have been repeatedly underfunded due to hospital financing and health coverage policies.[20]

Disparities in Health Care Affordability: Insurance & Medical Debt

From the patient's perspective, the most immediate cause of COVID-19's disproportionate impact on people of color may be an inability to access quality, affordable health care. Lack of access to insurance and high medical costs are major deterrents to seeking testing and treatment.[21] Both issues are more prevalent for people of color than for white people, nationally and within the five boroughs (see table).[22]

[20] Bryan Rosenthal et al., "Why Surviving the Virus Might Come Down to Which Hospital Admits You," The New York Times, July 1, 2020, https://www.nytimes.com/2020/07/01/nyregion/Coronavirus-hospitals.html.
[21] Kaiser Family Foundation, "What Issues Will Uninsured People Face with Testing and Treatment for COVID-19," March 16, 2020, https://www.kff.org/uninsured/fact-sheet/what-issues-will-uninsured-people-face-with-testing-and-treatment-for-covid-19/.
[22] Samantha Artiga, Kendal Orgera, and Anthony Damico, "Changes in Health Coverage by Race and Ethnicity since the ACA, 2010-2018, Kaiser Family Foundation, March 5, 2020, https://www.kff.org/disparities-policy/issue-brief/changes-in-health-coverage-by-race-and-ethnicity-since-the-aca-2010-2018/ and Jamila Taylor, "Racism, Inequality, and Health Care for African Americans," The Century Foundation, December 19, 2019, https://tcf.org/content/report/racism-inequality-health-care-african-americans/.

Percent of Population Without Health Insurance by Race, 2019				
	White, excluding Hispanic or Latino ethnicity	Asian	Black/African American	Hispanic or Latino, any race
Bronx	4.8%	5.4%	6.6%	9.3%
Brooklyn	4.1%	5.5%	5.8%	11.0%
Manhattan	3.0%	4.6%	5.2%	6.7%
Queens	3.5%	9.9%	7.3%	15.1%
Staten Island	2.9%	3.0%	3.1%	8.9%

Source: 2019 American Community Survey, Table: Selected Characteristics of the Uninsured in the United States

These disparities have become worse during the COVID-19 pandemic. Thousands of New Yorkers have lost health coverage because of the pandemic and its resultant economic downturn. But loss of coverage has been worse for communities of color: African Americans in New York City reported losing health insurance twice as often as white New Yorkers (14 percent of all households compared to 6 percent);[23] and Latinx New Yorkers reported losing health insurance nearly four times as often as white New Yorkers (23 percent compared to 6 percent).

Likewise, in Brooklyn, Manhattan, and Staten Island, there are differences in the number of residents with medical debt in collections depending on whether the community is majority people of color or majority white. In Brooklyn, zip codes where more people of color live had 4 percent more residents with negative credit reports related to medical debt than zip codes with fewer people of color.

Disparate Impact of the Share of Residents with Medical Debt in Collections			
County	**White Communities**	**Communities of Color**	**Difference**
Kings	3%	7%	4%
New York	2%	4%	2%
Richmond	4%	5%	1%
Bronx	6%	6%	0%
Queens	5%	5%	0%

Unfortunately, New York's non-profit, charitable hospitals are substantially responsible for these observed disparities in medical debt. In March 2020, CSS published a report, *Discharged into Debt*, which documented that some of New York's non-profit hospitals are

[23] James A. Parrott and Lina Moe, "The New Strain of Inequality: The Economic Impact of COVID-19 in New York City," The New School Center for New York City Affairs, April 15, 2020, https://static1.squarespace.com/static/53ee4f0be4b015b9c3690d84/t/5e974be17687ca34b7517c08/1586973668757/NNewStrainofInequality_April152020.pdf.

highly litigious, contrary to their putative charitable missions. [24] In the past five years, these non-profit hospitals have sued over 40,000 New Yorkers in nearly every county of the state. About 6,200 of those lawsuits were filed against residents of New York City. An interactive map of these lawsuits by county, listing the hospitals who bring them, is posted on our website.[25]

Many hospitals aggressively have continued to file lawsuits against patients throughout the pandemic. At least 70 New York City residents were sued between March and October 2020, 63 of them by hospitals that are part of the Northwell System. These lawsuits were filed even though courts in New York City were not taking civil cases for most of the year. The case of Janet Mendez, recently profiled in the *New York Times* with a $400,000 bill for her COVID treatment, underscores the problem.[26]

The chart below lists the medical debt lawsuits between March and August 2020 by the name of the hospital:

Lawsuits Filed by Hospitals Between March and October, 2020	
Hospital	**Number of Lawsuits Filed**
Staten Island University Hospital	28
Lenox Hill Hospital	16
Long Island Jewish Medical Center	13
North Shore University	6
NYU	3
Brookhaven Memorial	2
Richmond University Hospital	2
Total	70

[24] Amanda Dunker and Elisabeth Benjamin, "Discharged Into Debt: New York's Non-Profit Hospitals Are Suing Patients," March 2020, https://smhttp-ssl-58547.nexcesscdn.net/nycss/images/uploads/pubs/2020_Hospital_Report_V3_web.pdf.

[25] Mapping How New York's Hospitals Due Vulnerable Patients, available at: https://www.cssny.org/news/entry/mapping-how-new-yorks-hospitals-sue-vulnerable-patients

[26] J. Goldstein, "She Survived the Coronavirus. Then She Got the $400,000 Bill." The New York Times, June 15, 2020.

What Can the City Council Do to Help Ameliorate These Disparities?

Much of these structural financing and planning problems are set by the federal and state governments. However, the City Council can take steps to make life fairer at the City level.

1. The City Council should pass Intro 1674-2019, which would establish an Office of the Hospital Patient Advocate. This measure would help document the patient experience at hospitals, the care that they received, and potentially abusive collections practices It would also help monitor disparities in care and make recommendations about how to promote a more equitable health care system at in New York City.

2. The City Council should investigate city property tax exemption and zoning rules for New York's non-profit hospitals and consider "right sizing" these rules so that tax and zoning benefits lead to more equitable placement of health care facilities in underserved communities.

3. The City Council should augment funding for community-based organizations who help patients enroll in health coverage and address medical debt. Programs such as the Access Health NYC and MCCAP programs leverage trusted agencies in low-income communities of color to ensure that patients are able to enroll in coverage, apply for financial assistance, or resolve medical debt problems.

Thank you again for providing me with the opportunity to testify at today's important hearing. Information about programs that CSS operates that can assist your constituents is provide below. Should you have any questions or seek further elaboration, please do not hesitate to contact me at: ebenjamin@cssny.org or (212) 614-5461.

Community Health Advocates (CHA)
Community Health Advocates is New York's statewide health insurance consumer assistance program under the Affordable Care Act. CHA helps New Yorkers navigate the complex health care system, use their health insurance, and access the health care they need. CHA helps New Yorkers through a toll-free live-answer Helpline and a statewide network of 27 community-based organizations.

CSS Navigator Network (CNN)
CNN offers health insurance enrollment assistance through community based and small business serving groups. We help New Yorkers and small businesses shop for and enroll in health coverage through NY State of Health Marketplace. CSS partners with 18 community-based organizations and small business-serving groups to serve 54 of New York's 62 counties.

Independent Consumer Advocacy Network (ICAN)
ICAN is the New York State Ombudsprogram for people with Medicaid who need long term care or behavioral health services. ICAN helps New Yorkers with enrolling in and using managed care plans that cover long term care or behavioral health services. ICAN provides education and one-on-one assistance through a statewide network of 17 community-based organizations and a toll-free live-answer Helpline.

Community Health Access to Addiction and Mental Healthcare Project (CHAMP)
CHAMP is the New York State Ombudsprogram to help individuals and their families resolve issues in accessing substance use disorder and mental health services. CHAMP is a joint project of the Office of Alcoholism and Substance Abuse Services (OASAS) and the NYS Office of Mental Health (OMH). CSS partners with three specialist agencies and five community-based organizations and operates CHAMP's toll-free live-answer Helpline.

New York State NURSES ASSOCIATION One strong, united voice for nurses and patients

New York City Council Oversight Hearing -Committee on Hospitals:

Examining the City's Support of NYC Hospitals during the COVID-19 Pandemic

November 5, 2020

Testimony of the New York State Nurses Association

Presented by Kim Behrens, RN

My name is Kim Behrens. I am a registered nurse employed by NYC Health + Hospitals at Bellevue Hospital. I have worked for Health + Hospitals since 2009.

I am testifying today on behalf of the New York State Nurses Association, which represents more than 20,000 registered nurses in the New York City area and almost 10,000 nurses employed by the H+H system.

Throughout the COVID crisis, I have regularly worked in the Bellevue emergency department and directly experienced the impact of COVID on our patients and on the nurses and other direct care staff on the front lines.

During the first COVID surge in March and April Bellevue and the H+H hospitals were severely impacted by wave after wave of extremely sick patients. This crisis and the City's response highlighted several systemic weaknesses that presented serious problems for the front line staff and for patient care.

As we enter into a resurgence of the COVID pandemic over the fall and winter, it is critical that these problems are immediately addressed before the next COVID surge arrives.

Insufficient Staffing at NYC Health + Hospitals

During the height of the first phase of the crisis, hospitals in the City were directed to increase their bed capacity by at least 50% and the state added tens of thousands of ventilators to accommodate increased ICU patient needs. At the high point of the first surge, our hospitals were able to add beds to accommodate the flood of COVID patients, but adding beds and ventilators is meaningless without the trained nurses and other staff needed to actually provide the patient care.

The Health + Hospitals system has suffered from chronic staffing problems, particularly in comparison to the richer academic medical centers. In our most recent collective bargaining agreement with the City we agreed to minimum staffing ratios in the emergency department and on acute care units, but they have not been fully implemented. The State of New York has not yet enacted legislation at the state level to implement minimum staffing ratios through DOH regulation or legislation.

The lack of minimum staffing standards was a massive problem during the first surge.

In the ED we did not have enough nurses to provide the level of care needed by our patients. On the ICUs and COVID units upstairs our nurses found themselves assigned to care for 4 or 5 or 6 or more patients, greatly exceeding the minimum standard of 1 nurse to 2 patients.

In addition to the insufficient numbers of nurses, we also encountered a problem of temporary or agency nurses being brought in to assist the regular staff who were untrained or unable to provide care for acute and intensive care patients.

In the Bellevue ER I have often been struck by the fact that there are often more police officers guarding arrested patients than there are nurses to provide patient care. When the police bring in a patient, there are always at least 2 officers and sometimes as many as 6 or 8 per custodial patient. It is ironic that the NYPD has rules for the number of officers needed to guard a patient in our ER, while there are no rules for the number of nurses needed to provide patient care.

The lack of staff was made worse during the crisis by reliance on temporary or agency staffing that was costly and ineffective.

Temporary agency staff were hired, at salaries that were much higher than what the regular staff are paid, but they did not always or fully contribute to caring for COVID patients. Many had little or no ICU or acute are experience and did not significantly ease the load on the regular staff. In many cases these temporary staff were not effectively supervised by management and did not end up taking on the responsibilities for which they were being paid. There were cases that I observed where these temporary staff disappeared from units or sat around doing nothing while the regular staff frantically tried to cope with the crash waves of patients.

Though I understand the urgency of the need to find staff during the height of the crisis, I believe that the City needs to ensure in future that any temporary staff that is hired is (a) properly credentialed, (b) experienced in providing acute care, and (c) properly supervised to ensure that they are supporting the regular staff in providing patient care.

As the next COVID surge approaches, we are concerned that we will once again find ourselves without sufficient staff to meet patient care needs. The City and NYCHH need to prepare now to add more regular staff in our hospitals and to identify and train any temporary staff to provide patient care before the next surge starts.

Inequalities in the hospital system

In addition to the issue of inadequate staff and a lack of enforceable staffing ratios to protect patient care and the workload of nurses, I also want to call attention to the differences between the conditions in the public hospitals and the large private hospital systems.

These inequalities were very acutely visible in several areas during the height of the surge in March and April.

First, NYCHH nurses had to deal with a much worse PPE situation.

Nurses at NYCHH were required to reuse a single, disposable N95 respirator for up to seven days. Many nurses were told to continue to reuse or to repair damaged respirators. Many nurses were told that they did not need N95s even though it was apparent that the virus was airborne in addition to being spread by droplets and through contaminated surfaces.

The rationing of the distribution of respirators and other PPE (such as gowns, hoodies, visors, goggles was not based on science or sound infection control protocols, but rather was driven by shortages of PPE equipment.

Many of the private sector hospitals, on the other hand were able to secure and distribute ample supplies of PPE to their nurses. Based on my contacts with nurses at other hospitals, I know that there was little or no rationing of PPE after the initial phase. At NYCHH, we are still rationing PPE.

The unequal distribution of PPE within the broader hospital system had serious consequences for nurses and patients at H + H. Many nurses at Bellevue were unnecessarily exposed and sickened. This in turn made the already bad staffing situation worse, as many nurses were forced to call out sick.

The inequalities between NYCHH and other hospitals also affected working conditions. Nurses at Northwell and other private hospitals received significant "COVID" bonuses throughout the surge, while NYCHH nurses did not receive any extra pay. The failure to provide supplemental pay to NYCHH nurses is also contributing to staffing imbalances, as many recently hired nurses leave the public hospitals to take higher paying positions in the private hospitals.

As NYCHH nurses became sick during the first surge, they received a notice from management demanding that they return to work even if they were exhibiting symptoms.

These inequalities in the way staff are treated have worsened the long standing making dynamic under which NYCHH serves as a free training ground for nurses who are hired by the large private networks. I am constantly frustrated to find myself as an experienced nurse having to train new hires, only to see them leave after six months or a year to take higher paying jobs elsewhere. This is a waste of money and resources that must be curbed by increasing the incentives for new hires to stay at Health + Hospitals.

Unfair funding of Health + Hospitals

At the end of the day, the City of New York has to provide equal funding for the H + H hospitals as a matter of justice for patients and for the front line staff.

NYCHH is the backbone of healthcare in New York City. We provide core emergency, acute and primary care services to some of the most underserved New Yorkers, but we do not get our fair share of resources to do this. That is why we are still understaffed and continue to ration PPE even before the next COVID surge.

We saw how COVID disproportionately affected our patients and our communities, with mortality and hospitalization rates for Black and Latino patients that were more than twice those for wealthier white patients.

If we are going to address these problems, it is imperative that we properly support NYCHH with subsidies that reflect the vital role that we play.

We also need to address the growing numbers of uninsured and underinsured patients in the face of an ongoing health care and economic crisis.

In the face of an imminent COVID resurgence that we are not prepared to handle, it is imperative that the City makes sure that H + H receives immediate funding to improve staffing, keep nurses from leaving, provide proper PPE and allow us to care for the next wave of COVID patients.