CITY COUNCIL
CITY OF NEW YORK

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TRANSCRIPT OF THE MINUTES

Of the

COMMITTEE ON HOSPITALS

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HELD AT: Remote Hearing

B E F O R E: Carlina Rivera
CHAIRPERSON

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

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

Mitchell Katz, President and CEO
Health and Hospitals

Deanne Criswell, Commissioner
Department of Health and Mental Hygiene

Jackie Bray, Deputy Executive Director
New York City Test and Trace Corps

Maura Kennelly, Associate Commissioner
for External Affairs
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Jenna Mandel Ricci
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Community Service Society

Christopher Schuyler, Senior Staff
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Commission on Public Health Safety

Judith Cutchin, Nurse at Woodhall
Health and Hospitals
President
Health and Hospitals Executive Council

SERGEANT-AT-ARMS: At this time, would all Sergeants please start the recordings?

SERGEANT-AT-ARMS: Computer recording started.

SERGEANT-AT-ARMS: Thank you.

SERGEANT-AT-ARMS: Cloud recording started.

SERGEANT-AT-ARMS: Thank you.

SERGEANT-AT-ARMS: Backup is rolling.

SERGEANT-AT-ARMS: Thank you. Good morning, everyone and welcome to today's remote New York City Council hearing on the Committee of Hospitals. At this time, would all panelists please turn on their video? Once again, would all panelists please turn on their video? To minimize disruption, please place all electronic devices on vibrate or silent mode. If you would like to submit testimony, you may do so at testimony@council.nyc.gov. Again, that is testimony@council.nyc.gop. Thank you for your cooperation. Chair Rivera, we are ready to begin.

[gavel]

CHAIRPERSON RIVERA: Good morning, everyone. I hope everyone is doing well, all things considered. So, good morning. My name is Carlina

Rivera and I am the Chair of the Committee on Hospitals. I would like to start by thanking all of you who have joined us for this remote hearing. We are here today to examine the city's support of hospitals during the COVID pandemic with a focus on the support provided during the spring. There is no easy way to recap what the spring was like for those of us in New York City. Our city experienced an incredible amount of trauma. Thousands of deaths, immense levels of fear and panic, loss of work, and in unprecedented shutdown of most of the city. Our healthcare system was pushed and stretched in unimaginable ways. It is incredible to think that just a few months ago, New Yorkers were applauding our frontline workers every night. Just give me one moment. Thank you for your patience. This is the new normal. I know that our city leaders, hospital staff, and essential workers were working around the clock to protect and save the lives of New Yorkers. And while the worst of the spring is over for now, we know the work has not ended. So, I want to start by acknowledging this and using this reminder to help frame our discussion today. Thank you to everyone present who was working during the spring, including

Dr. Katz and Health and Hospitals, representatives of other hospitals, as well as Department of Health and Mental Hygiene and the New York City Department of Emergency Management for their work. I want to especially thank H&H and DOHMH for their hard work which they managed to do while simultaneously keeping myself, the Council, and the city informed and updated on COVID 19 and how to stay safe. Your presence here today and continued collaboration is very much appreciated. Now that we have, fortunately, had some months of the easing of restrictions, significantly less hospitalizations, more availability of testing and supplies, and generally a more relaxed city, we want to know exactly what it takes to support our cities hospitals during the pandemic. City agencies coordinated a massive amount of PPE and other medical supplies, production, and distribution, oversaw and assisted with the dramatic increase in the city's hospital capacity and staffing, and provided countless public health messages to New Yorkers. We acknowledge that it is extremely impressive the amount of effort that went into these actions and, today, we want to discuss that work, as well as the concerns raised

during the peak and afterwards. For example, we are aware of hurdles faced by healthcare workers looking to help during March and April, issues with patient transfers, concerns regarding access to PPE, and long-term implications of people being unable to access non-COVID related care during the spring. We also know that this pandemic has and continues to disproportionately impact black and Latino New Yorkers, as well as other traditionally marginalized populations. This shouldn't come to us apprised to us because of our society's pervasive perpetuation of systemic racism. Our healthcare system is no different. Our public hospital system and other safety net hospitals have face long-standing inequities themselves. They are underfunded and they are under resourced. They are located in the city's hardest hit communities, including those hold to the city's most diverse residence and serve those who are underinsured and uninsured. Our public hospitals were the busiest in the city because they serve communities impacted by systemic inequities and because they themselves experience funding inequities. They did everything in their power to serve New Yorkers and they, frankly, you should not

have needed to fight so much to meet the needs of their patients. This pandemic proves that our healthcare system is to disparate, not just in times of crisis, but year round. Our public and safety net hospitals require the most attention and support and we want to ensure the city did all it possibly could to prioritize their needs. We are committed to ensuring that the path we build forward out of this pandemic is more equitable for all. Thank you again for attending today and I want to acknowledge some of my colleagues who have already joined us. I see Council member Moya, Ayala, Levine, Maisel. That's all I see for now. Sure we will be joined by others as the time goes on. And, with that, I want to turn it over to our Committee counsel.

COMMITTEE COUNSEL: Thank you, Chair. My name is Harbani Ahuja and I am counsel to the Committee on Hospitals at the New York City Council. Before we begin, I will be going over some procedural items. I will be calling on panelists to testify. I want to remind everyone that you will be on mute until you are called on to testify when you will be on muted by the host. Please listen for your name to be called. I will be periodically announcing who the

next panelist will be. For everyone testifying today, please note that there may be a few seconds of delay before you are on muted and we thank you in advance for your patience. As a reminder, all hearing participant should submit written testimony to testimony@Council.NYC.gov. At today's hearing, the first panel will be the administration followed by Council member questions and then the public will testify. During the hearing, if Council members would like to ask a question, please use the zoom raise hand function and I will call on you in order. I will now call on members of the administration to testify. Testimony will be provided by Dr. Mitchell Katz, president and CEO of New York City Health and Hospitals and Diane Criswell, Commissioner of New York City emergency Management. Additionally, the following representatives will be available for answering questions. Jackie Bray, Deputy executive director of the New York City test and trace Corps and Maura Kennelly, associate commissioner of external affairs for the New York City Department of Health and Mental Hygiene. Before we begin, I will be administering the oath. Dr. Mitchell Katz, Commissioner Deanne Criswell, Deputy Executive

Director Jackie Bray, associate commissioner Maura Kennelly. Please raise your right hands. Do you affirm to tell the truth, the whole truth, and nothing but the truth in your testimony before this committee and to respond honestly to Council member questions? Dr. Katz?

DR. MITCHELL KATZ: I do.

COMMITTEE COUNSEL: Thank you. Commissioner Criswell?

COMMISSIONER CRISWELL: I do.

COMMITTEE COUNSEL: Thank you. Deputy executive director Jackie Bray?

JACKIE BRAY: I do.

COMMITTEE COUNSEL: Thank you. And associate commissioner Maura Kennelly?

MAURA KENNELLY: I do.

COMMITTEE COUNSEL: Commissioner Criswell, you may begin when you are ready.

COMMISSIONER CRISWELL: Thank you. Good morning, Chairperson Rivera, and members of the Committee on Hospitals. I am Commissioner Deanne Criswell and I'm happy to be here today on behalf of New York City Emergency Management. I am joined today by Dr. Mitchell Katz, the Pres. and Chief

Executive Officer of the New York City Health and Hospitals, Maura Kennelly, associate commissioner for external affairs, Deputy executive director Jackie Bray, Deputy Executive Director of the New York City Test and Trace Corps. While New York City Emergency Management 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, New York City emergency management started to prepare for the inevitable. COVID-19 in New York City. Emergency management activated the city's emergency operations center on February 1 to implement the federal quarantined directives and built 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 and 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, New York City emergency management worked with our hospital partners to expand the number of readily available ICU beds in existing facilities and a number of institutions, including the Brooklyn Center for rehabilitation, the Borough Park Center for rehabilitation and nursing, North Central Bronx Hospital, and Kohler Hospital. This process provided emergency management with invaluable experience and information about how to prepare for a second wave and future pandemics. New

York City emergency management also 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 style that rapidly placed volunteers in the hospitals and worked with airline partners to fly them in for free. We also coordinated the request and placement of medical providers from the United States Armed Forces who provided care in all of our public hospitals. Additionally, we coordinated the medical reserve corps operations 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 healthcare workers to aid in the response. In total, over 5600 volunteer and contract staff were placed in healthcare institutions. Emergency Management also worked with our city partners to help procure critical medical supplies for healthcare facilities through our logistics center. In consultation with the Department of Mental Health and Hygiene and the public and private hospital systems, we facilitated the 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 the Office of Management and Budget, Department of Design and Construction, the Economic Development Council, and numerous other agencies to put in place contracts and vet potential suppliers during a time of dyer need. Throughout this pandemic, the city has also been keenly aware of the crucial need to share up to date information with New Yorkers, especially as guidance and protocols changed as the virus and the city's response evolved. The Notify NYC team launched a short code messaging program to ensure New Yorkers received 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 Emergency Management used this to send text message alerts via Spanish. We translated the 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 currently 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 stopped responding. I am happy to take any questions that you may have. Thank you very much.

COMMITTEE COUNSEL: Thank you for your testimony. Dr. Katz, you may begin your testimony when you're ready.

DR. MITCHELL KATZ: Thank you very much. And I want to thank Chair Rivera for having this hearing and particularly for her for recognizing the trauma. And I appreciated that she used that word because the events of March and April really were traumatic for the amazing staff of Helping Hospitals. We lost a lot of love staff during that time. People worked through the most difficult conditions worried about their own health, worrying that they might bring home illness to their loved ones. They worked in credible hours. They worked

under incredibly stressful conditions. They often took care of their own colleagues. Nurses took care of sick nurses. Doctors took care of sick doctors. I mean, you can imagine how strong the empathy would've been and how challenging it would have been. And also I think underappreciated who did most of that work. Women. Right? People don't always recognize that. But there was a brilliant article done on the women of Elmhurst recognizing that three fourths of the people who work at Elmhurst, the epicenter of the epicenter were women, starting with the Chief Medical Officer Dr. Jasmine Mashapur, and immigrant herself who has spent 50 years working at Elmhurst. And those are the people who struggle to keep everyone alive despite the incredibly difficult circumstances of COVID. We did our best. I thought Chair Rivera got it right. It was awful, but people did their best. We started preparing as soon as we heard about what was going on in Wuhan. We opened up our emergency center. We canceled elective surgeries so that we would have more staff. We converted our routine face-to-face visits to tele visits to protect people from having to go out and potentially expose themselves. We did the most massive increase in ICU

creation and that probably has ever been done in this country and, if you asked me, as someone who spent his career in public hospitals, Mitch, how long do you think it would take you to the triple your ICU capacity? I would've said, I don't know. Maybe two years. Three years. It would take, you know, something like that. You would have to get the equipment and the staffing and the space. We did that in six weeks. We went from having no COVID patients on March 1 to having almost 4000 by mid-April. We went from having zero intubated COVID patients to having 960 COVID patients in our facilities. I read from Times newspaper articles about other areas of the country and I feel sympathetic, but they usually talk about how they are about to reach capacity of their ICUs and they don't know what they are going to do when they reach capacity. And I can't help but think, oh, my God. We would reach capacity by week one. Capacity wasn't the issue. The issue was how quickly can we create new ICU bed? And, of course, the most important at element in creating the beds are the people. And, you know, again, I think that was undoubtedly during lesson of COVID and it is something I think about a

lot in terms of how you go forward. In the end, space was not the issue. The issue is people having enough doctors, not enough nurses, net of respiratory therapists, and getting them through these incredible traumatic time. But I think that we did as well as one could possibly have done. In terms of the alternative sites, the one that worked best for us was the RIMC, the Roosevelt Island Medical Center, which we stood up and have now closed down. It was able to take patients who would've gone home if they had a home, but because they didn't have a home or their home was a multi-generational family or their home wouldn't be able to provide them enough support services. We were able to care for them at RIMC once they were no longer acutely ill. We did a lot of transfers. I want to thank the board, the Mayor, for maintain a robust hospital system. The city, you know, deserves tremendous credit. I've only had the privilege of being back here for three years, but it is because of all of you that there are 11 public hospitals in New York City. Remembering that Boston, Philadelphia, Washington DC, Milwaukee, Sacramento, San Diego. All of these places used to have public hospitals and they don't have any. And the thing

that ultimately saved us was that we had 11. So, with central Queens so affected and, as Chair Rivera said, people came to us because they trusted us. Because they knew that Elmhurst was a safe place to go where you wouldn't be reported to the federal authorities where you would be sent a bill, where people would speak your language, where people would treat you with dignity. So they came to us, but in order to be able to serve people, we transferred patients, almost 900, cross our 11 facilities and places like north-central Bronx were amazing and I still remember going to visit there and who was taking care of our patients? The midwives. The midwives of NCB, you know, stood up to take care out of the ICU patients who needed their care who were coming from Queens. But everybody stood up in order to take care of our patients the way they needed to take care of. We added 5000 nurses, 1500 other health practitioners. They came mostly from temporary agencies staffing that we use. People came from around the country. We got great support from the Department of Defense and people asked me, you know, was there any culture, you know, problems? And there was zero. You know, the people who showed up

showed up to do a mission and whether they were, you know, a nurse civilian or they were a nurse from the Army, people really responded. We did a lot of work with Helping Healers Heal. We are still doing that. I do believe that there are a number of my staff who have posttraumatic stress syndrome who feel really hurt because what is it that they heard about? They feel that they would've liked to have done more for their patients. And I know, as a practicing physician, that is a terrible feeling. You always want to feel that, whatever happened to your patient, you did everything that you could have done to help them. But, of course, when people have loads of patients that were three times larger than the normal load, they did their best. They saved lives. But I know a number of people still, you know, lose sleep, wake up in the middle of the night feeling, you know, upset, dramatize that they wished that they could have done more. Certainly the city-- and I think Deeann. I thanked Jackie Bray. I was with them, you know, 11 PM at night as we were talking about, you know, as plain to go get more PPE. You know, who knows how to make gallants? What could be a way of making gallons to protect my workers? They work so

hard to try to get us the supplies. And, in the end, we never ran out, although we came perilously close to running out multiple times, but we never did. Often at those hours I was moving around with my staff ventilators from one place to another to be sure that we always had just enough and we always had just enough. It wasn't-- and I think this hasn't always been understood-- part of the challenge for the PPE, especially the N95 masks, was when you train people to use N95, you train them. Okay. You go into the room. You see your patient with the infectious disease. You go out of the room when you throw away the N95 mask. That's how we train people. That is what life is supposed to be like. But, of course, that wasn't what life was like and, frankly, people were taking care of whole wards of people with COVID, so there wasn't any great value in taking off their mask. It would have only exposed to them. But I say that to help explain why it was that, even though we didn't run out, people were justifiably upset. They were looking at, well, but the supplies will never last. So, imagine you were at work today and you know that there is a mask for you today, but there's not enough masks for you tomorrow, you know,

and you thinking about coming to work tomorrow. We did a lot of just in time supplies. That is what we had to do and I am just so grateful to the other people to make sure that we didn't run out. We did a lot of outpatient work. We answered 80,000 calls, multilingual, real doctors telling people what to do so that they were able to get through the time at home without coming to the hospital unless they absolutely had to. So, I'm looking forward to the discussion, to your question, Chair Rivera, and the questions of your colleagues. Thank you.

COMMITTEE COUNSEL: Thank you for your testimony. I will now turn it over to question from Chair Rivera. Panelists, please stay on muted, if possible, during the question and answer period. Thank you. Chair Rivera, please begin.

CHAIRPERSON RIVERA: Thank you so much and thank you for your testimony. Of course, it is very much appreciated and I just want to say I appreciate you acknowledging just all the people that we have lost and there are many people behind the scenes right now that are a part of the Council who lost family members and friends and, you know, as they participate in this hearing and make it happen,

I just want to acknowledge all of their loss, as well. Dr. Katz, commissioners, I want to thank you again for being here. I know that your time is very, very precious. We are still in the midst of the pandemic, so I will try to go as quickly as I can through these questions and see if my colleagues have any, as well. So, we heard a lot about PPE, of course. I think that kind of distribution, medical equipment, access, and availability is probably the most important-- what are the most important topics in terms of what we saw in the news as being very, very limited. We talked a little bit about redistributing it, never quite being out of PPE and then, of course, some of the stories that we saw as to whether staff really did, indeed, have everything they need in unprecedented times. So, in terms of PPE distribution, by April 4, DOH MH had distributed over 1 million N95 respirators, millions of facemasks, and tens of thousands of gloves, gowns, and face shields from the city, state, and federal stockpiles and private donations to the city's hospitals, nursing homes, and emergency medical services. How did the city develop its PPE distribution process? How was PPE distribution

determined and how did you work with hospitals outside of the Health and Hospitals system to make sure that there was an equitable distribution, if that indeed happened?

DR. MITCHELL KATZ: I think we're going to have Jackie address it since she spent many a long night working on that distribution. Jackie? Jackie was just here. I saw her little box. Are you on mute? Deanne, do you want to start until Jackie restores?

CHAIRPERSON RIVERA: She's logging in. it happened. We're working on universal broadband for all.

DR. MITCHELL KATZ: Great initiative.

CHAIRPERSON RIVERA: Her audio is connecting. So, Jackie, I think you might've missed some of the conversation. We're going to unmute you and if you want me to repeat the question, I'm happy to do that. It's not a problem. You just have to unmute the deputy-- Jackie, do you want me to repeat the question?

JACKIE BRAY: I'm sorry. Yes. Please do.

CHAIRPERSON RIVERA: It's okay.

JACKIE BRAY: I'm sorry about that.

CHAIRPERSON RIVERA: It's okay. It's absolutely okay. I'm just glad that you are here. So, my question is about PPE distribution. I mentioned over a million N95 respirators, facemasks, gloves, gowns, face shields, all of those stockpiled, the private donations to the city's hospitals, nursing homes, and emergency medical services, how did the city develop it's PPE distribution process? How was PPE distribution determined and how did that work with hospitals outside of Health and Hospital systems if that sort of coordination did, indeed, happen at all?

JACKIE BRAY: Sure. Of course. So thank you for the opportunity to answer that question. The city had really two ways of distributing PPE throughout March and April and into May. The first is that, at any time, any healthcare facility could make an emergency request through the [inaudible 00:30:37] New York City Office of Emergency Management logistics center and those emergency requests, by and large, were fulfilled within 24 hours assuming that we had whatever the request was for on hand. But as the hospital instances began to increase in early March, the city made the decision--

the Department of Health and Mental Hygiene made the decision to begin pushes of PPE. So instead of waiting for hospitals to request what they needed on an emergency basis, DOHMH began to push out twice a week, you know, stocks of PPE to 55 hospitals across the city. H&H were 11 of those 55, but we were supplying twice a week, every week, by mid-March all the city's hospitals. All the hospitals in the city, both independent and the big five systems. And we made decisions about to allocate to each hospital based on the number of but we did COVID patients they had and based on them all you that their emergency department, there are emergency room were experiencing the COVID patients. And those decisions were made in partnership between the Department of Health, H&H, Greater New York Hospital Association, the city, and the state.

CHAIRPERSON RIVERA: And can you confirm that Health and Hospitals were probably the hospitals that needed the most PPE considering your criteria for how they were distributed with the admitted patients, with the census that you mentioned? You know, 55 hospitals, some of them are in very, very different conditions in terms of their financial

support, terms of the wealth of the neighborhoods that they are in. So, how did you ensure that you were really being as proactive and as reactive as possible to some of our hardest hit within those neighborhoods?

JACKIE BRAY: Yeah. So, we always made sure that Health and Hospitals had what they needed. The lady our top priority and we spent, as a team, between the Department of Health and myself and the supply chain team that is working for Dr. Katz, many hours every day on the phone ensuring that Health and Hospitals had what they needed. The city took a specific book to make sure that both the public hospitals and the independent hospitals, the smaller community-based hospitals, had what they needed and we stayed in very close touch with the big systems and Greater New York to ensure that they were okay. So I would say that, yes, we prioritized making sure that our independent hospitals and our public hospitals had what they needed, but, really, throughout March and April, we were supplying all 55 hospitals that were seeing COVID patients.

CHAIRPERSON RIVERA: So, in the spring there was an international shortage of PPE and the

assistance then New York City received from the federal administration clearly was not enough and I think we continued to be shorted, but the city mobilized to create its own PPE. We saw a little bit of that of the local manufacturing. Some of the locations in the city. Does the city have the capacity to manufacture most or all of its own PPE?

DR. MITCHELL KATZ: Jackie?

JACKIE BRAY: Yeah. Go for it. For sure.

DR. MITCHEL KATZ: No. No. Jackie, I want you to answer it.

JACKIE BRAY: Okay. You know, EDC-- and I believe that EDC testified either last week or a couple weeks ago, too, on this topic. The Economic Development Corporation here in the city stepped up from day one and began to do both an analysis of supply chain and an analysis of what we could manufacture here in the city. What we learned is that some things we could manufacture. For example, face shields. By mid-April, the city was making enough face shields to supply our entire burn rate right here in the city. Some things were much, much harder. The city never attempted-- could never manufacture N95s within the city. And so, there was

a real analysis done. What we could manufacture here, we were manufacturing here, but some things take a much longer-- much more infrastructure set up. And that wasn't realistic to get off the ground in March and April. By the end of April, by early May, the supply chains were coming back and so we were really working-- we kept saying we were working multiple strategies. We were going to buy, right? We were going to buy, we were going to build ourselves, and if we had to, we were going to borrow. And we were always working all three of those strategies at the same time throughout the spring.

CHAIRPERSON RIVERA: So, what's the city's current PPE stockpile compared to February 2020 and what interagency coordination is in place to ensure that appropriate stock-- to ensure appropriate stockpiles and allocation?

DR. MITCHELL KATZ: I'll start with Health and Hospitals and ask Jackie or Deanne to say for the whole city. For us, we have a three month reserve. And that's very different-- like most hospital systems in February, we would've had, you know, a week or two in the way of reserve because we always assumed that we would just keep buying and we

had-- as the Chair, you had pointed out-- the worldwide collapse of the supply chain took everybody by surprise. What we said about Wuhan, we just as a hospital system put in orders for all the PPE that we would've needed to get through the crisis and the orders were accepted. No one said in January, oh, you'll never get these. It was only when March and April came, those shipments never arrived. And that's why the wisdom of maintaining a reserve. So, aside from whatever reserves the city is holding, we're holding three months of supply for ourselves. Jackie or Deanne? I don't know which of you knows best the city cache.

COMMISSIONER CRISWELL: I can start on that, Jackie, and if I miss anything, please feel free to chime in.

JACKIE BRAY: Sure.

COMMISSIONER CRISWELL: So, the city has, since then, developed what we're calling a PPE service center. And so we have hired a vendor to manage those for us and so each hospital, even outside of the Health and Hospital system, our hospital systems and the independents all have their own 90 day supply of PPE and then, through our PPE

service center, we have an additional 90 day supply of PPE that can be utilized. I am also, as part of emergency management, monitoring what the state stockpiles are, as well as the strategic national stockpile, but I think where we are at right now with the hospital systems, as well as the city's service center, we are in much better shape than we were in the spring.

CHAIRPERSON RIVERA: Thank you. I appreciate that. I want to move on to ventilators. In early April, the city supply of ventilators was in a state of crisis. The Mayor estimated that the city needed an additional 2500 to 3000 more ventilators and there was a possibility that we would run out. Governor Cuomo announced the same day that he was authorizing the state's National Guard to seize ventilators from less overwhelmed hospitals so they could be used at hospitals that had a more urgent need. How is the city ensuring that each hospital was supplied with the ventilators that it needed?

DR. MITCHELL KATZ: Again, I'll start and I know Jackie did a lot of work-- we did a lot of work together on ventilators. Those, I remember seeing those projections and they, you know, drove a

knife through my heart at the time because it was impossible to imagine how we would have met that need. Fortunately, the projections were wrong and the great efforts of New Yorkers to flatten the curve worked and the number of cases leveled off. So, we never had that huge crisis that we would've imagined. We did come very close, though. We were on the few days only. And I know, in my own system, part of why I kept having to move ventilators was that I had to match ventilators to demand so that it was often, you know, that close where someone-- a hospital, if they were hit very hard on a particular night, harder than I had estimated, I would need to move right away enough ventilators for them to be able to make it through. I would say, before going to Jackie, one fortunate thing that we've now learned is that many patients are better off on BPAP or CPAP which are forms of non-invasive ventilation that don't require that you have an intubation tube down your throat. It's, instead, that you wear a mask that, at high pressure, pushes air into you and it has turned out, as we've learned more and more, that there are a large group of patients who do better with that care. That wasn't standard. That's one of the things that

explains why the death rate across the country has gone down. We're getting better at treating this illness, but those days of worrying about enough ventilators for the next day were just horrible. Jackie, we worked those nights together. What can you say about the rest of the city supply?

JACKIE BRAY: Yeah. Yeah. So no hospital across the city ever ran out of a ventilator, but as Dr. Katz said, we got close. And they were harrowing days and harrowing nights. The city for ventilator supply-- I should say that David Star is the assistant commissioner of emergency [inaudible 00:41:36] from the Department of Health and Mental Hygiene is one of the real unsung heroes of the March and April response. We had a number of emergency requests come in for ventilators for hospitals across the city. We were able to fulfill them all. We were working on a very small number of ventilators the city, ourselves, were able to buy [inaudible 00:42:02] an allotment from the state and an allotment from FEMA. At some point, FEMA delivered about 2500 ventilators that we were able to push out across city hospitals to both H&H and the independent hospitals, some of the big five systems, and then, of

course, we held on to a couple to meet emergency requests. I think that one thing to remember, which can be hard looking back on those days, is that we were working on planning assumptions that we had created in mid-March and late-March as the curve was-- as sort of we were climbing that mountain and because of the way the mitigation measures work, they take 14 days for you to see it in the cases and it can take even an extra week or two to see it in the hospitalizations. And so we were watching, you know-- you needed to deploy another 200 ventilators a night or 300 ventilators a night. We were watching the city's numbers go up like that hoping, knowing, thinking that we had done the right thing two to three weeks prior where it was going to break. But we never knew until it broke. We didn't know what day it was going to break. And so that's kind of the dynamic we were in in that first week of April, sort of second week of April.

CHAIRPERSON RIVERA: Thank you. I just want to ask a few more questions. I see at least one of my colleagues also has questions. So let me jump to alternative care sites. H&H and the New York City Department of Emergency Management coordinated the

opening of large alternate care sites, including the Javits Center in Manhattan, the Billy Jean King Tennis Facility in Queens, and the Brooklyn Cruise Terminal. We also have help from the USNS Comfort and we'll talk about whether that was helpful or not. And a 350 bed field hospital at the Roosevelt Island Medical Center, in total, how many patients were transferred to these alternative care sites and, of the patients transferred, how many were from H&H? How many were from voluntary hospitals? And I--

DR. MITCHELL KATZ: Deanne, do you--

CHAIRPERSON RIVERA: Yeah. Sure. I just want to, really quick, we've heard that the sites could've been more successful if they had accepted COVID patients in need of higher levels of care as soon as they were opened, why was that not possible?

DR. MITCHELL KATZ: Deanne, do you want to start?

COMMISSIONER CRISWELL: Yeah. I'll start. So on the exact number of patients that were transferred, we'll have to get back to you on the number because I don't have those right inf front of me, but what is important to discuss is the point

that you just raised. And when we first started to develop these alternate care facilities and, specifically, the Jacob Javits Center and the US Naval Ship Comfort, those two-- the Jacob Javits Center was run by the stat in coordination with the city, but staffed by the Department of Defense and then the USNS Comfort was a purely federal asset that was run by them. And their initial planning assumptions that they has put in place when they were building those two-- or building the one site and bringing in the comfort was that they were going to treat non-COVID patients so they could take the pressure off the hospitals to them treat more COVID patients. And while, in theory, that sounds like it would've worked really well, what we found was that, across all of our hospitals, there just were any non-COVID patients. And so it took several days of conversations with leaders at the highest level at the Department of Defense and myself to really talk through what it was we needed here in the city and we eventually were able to change their planning assumption to be able to treat COVID-positive patients. But we still ran into some struggles with that and the fact that they still didn't have the

capability to treat those that were the most sick which is really what we were seeing across the hospitals, as well. And they were able to treat those lower acuity patients. And so we did have a hard time getting patients from the hospitals into these centers. What I would say, though-- and Mitch can talk about why we couldn't send so many low acuity patients there. What I would say is that, as we were building these-- and really to what Jackie said earlier, we didn't know how bad bad was going to get and so these facilities really gave us that resource that was available to use. What we did find at the end of the day was that patients were better off treated in the hospital than in these alternate care centers. And so, once we reached that point where we knew we had enough capacity and space at the hospitals, we did another shift and that was to take all of the-- not all, but a lot of the medical personnel that were staffing the Javits Center as well as the Comfort and moved them directly into the hospital to support the hospitals. And they went just to the public hospitals. And they went to all of them and they stood up their own wards to be able to increase the capacity of patient care in the

public hospital system. And so, what we learned was, while we went through a lot and it takes a lot of time put those up, we did discover that our hospital system has enough capacity and, at the end of the day, it's really staff that need to maximize the capacity that we have. Mitch, do you want to just talk a little bit about why we couldn't take the most critical over to those locations?

DR. MITCHELL KATZ: Right. I think that the lesson is hospitals are very specialized facilities and you can't just stand up a hospital, you know, in a non-hospital space and expected to care for intubated, ventilated, ICU patients. There's just too much that you need in equipment, I pharmaceuticals, in respiratory therapists, in ICU nurses, in a variety of X-rays, and that the idea of off-loading wasn't the-- the hospitals-- and again I remember these days very well. The hospitals were so busy keeping critically ill people alive that transferring mildly ill patients just wasn't a priority. It just-- the amount of effort to move a mildly symptomatic person wasn't worth it because we were, you know, putting all our effort into saving people's lives and the people who were mildly ill

were doing okay. And so it just wasn't the need and, as Deanne said, of course if those initial projections were right-- I mean, I still wonder how we would have ever staffed all of those places, but we would have needed space if we had got it that full when, happily, New Yorkers efforts flattened the curve before that was necessary.

CHAIRPERSON RIVERA: So, just a couple more questions and then I am going to turn it over to my colleagues. According to an investigation, you know, we are talking about patient transfers, so I want to ask a little bit about equity. According to an investigation by the Wall Street Journal, the city struggled to receive assistance from the state to set up a centralized hub to implement patient transfers. What exactly happened there? And I ask because there is always a question of health equity. I mentioned this in my opening remarks. During the Committee on Oversight and Investigations hearing this past April, over 40 expert panelists and community advocates highlighted that communities of color are experiencing higher fatality rates from COVID 19 due to systemic racism. And that this racism is evident through economic, health, and societal practices that

have taken place for decades. So, how did the administration take health equity related issues into account when it began to put together its virus response? And to go back to my first question, when trying to develop a hub so that way patients could be transferred and receive equitable care, what happened with assistance from the state to ensure that that equity became a reality? Though, ultimately, I will say we clearly lost more black and brown New Yorkers than any other kind of New Yorker which is incredibly tragic. But if you could just address how you did--

DR. MITCHELL KATZ: I'll start--

CHAIRPERSON RIVERA: And do better? Thank you.

DR. MITCHELL KATZ: I'll start. First, again, I think you captured it, Chair. I mean, we didn't succeed in equity. We failed in equity because a disproportionate number of black and brown people died. They died-- I mean, I think, since we haven't talked about it, they were much more likely to get infected because they were the essential workers. They were the people who ran our trains, who stocked our grocery shelves, who worked as home aides. They were living in multi-generational

families. They were, you know, married or had parents who were essential workers and so they got exposed a lot more and then we know that people who are black and brown, because of systemic racism, live in a state of chronic stress which is bad for your health. They are more likely to have hypertension and diabetes. They're more likely not to have good nutrition. So, I mean, the deck was stacked against people. And we did not succeed in achieving equity which I think is shameful. We did do our best to transfer patients and I think there's also a lesson to be learned here, right? And Chair Rivera, you've made this point before. If you compare the number of hospitals that Manhattan has to the number of hospitals in Queens, right, it's striking. Right? I mean, part of why Elmhurst was so overwhelmed is because there aren't other hospitals in Queens. And transfers were a very, very imperfect solution. And the reason I say that is that it's hard, medically, to transfer an unstable patient. And so, as much as we wanted to even things out among our 11 hospitals, which was our focus, it wasn't always easy because you can't put a patient into an ambulance to go to a less crowded hospital if you think they're about to

go into cardiac arrest from lack of sufficient oxygen. And you can't, while EMTs are phenomenal, they can't adjust ventilator settings. And so, you know, the problem we had, which is a little bit like the issue that we were discussing temporary settings. We could have always transferred many more of the stable patients, but they weren't the ones who were causing us the heartache and then the patients we most wanted to transfer because that's where we were overrun. We're so critically ill that it often was difficult to transfer them without risking their lives. And so, the state did become involved. I think toward-- you know, it was maybe around April 1 we did do some transfers. Because of the state, we accepted hospitalized patients from two independent systems which, again, you know, I give a lot of credit to this board and this mayor for maintain a robust enough public system that we could help out the independents. But we did not have an equitable system for transferring across the hospital systems. That it was tried but it came too late without enough process before it. Deanne, is there things I missed?

COMMISSIONER CRISWELL: I think, Chair Rivera, to speak directly to the question about the

ask from the state. We have what is called the Hurricane Evacuation Center Capability that we use when we have a pending costal storm and it's used-- it's a tool. It's a resource web-based application that is used to evacuate hospitals that are in the way of a hurricane to bed match them with patient needs. And so what we had asked was to modify that and use that system to help manage the-- what we were expecting to be a growing need for transferring patients across hospital systems. I think, as Dr. Katz had mentioned, transferring between hospital systems is something that they do on a normal basis, but across hospital systems is a little bit more difficult. And so that's the system that we were trying-- this hex system that we were trying to put in place to support the anticipated need for patient transfers. They never did activate it the way we had asked, but they did put a modified version in place and what it was used for was to transfer patients out of hospitals and then into these alternate care facilities that were managed by the state. What Emergency Management did was also then create a transportation branch specifically and that is the group of individuals that, when we did have the need

transfer some of the independents on an emergency basis, which we had a couple of times-- we were able to have that branch, that transportation branch, work with each of the different hospitals to identify places that we could move patients. And so we supported the work that Dr. Katz had mentioned, as well as some of the needs across the other hospitals through this branch.

CHAIRPERSON RIVERA: Well, thank you. I just want to thank you for all the work that you did. I realize, you know, we also could've used a lot of help from the federal government that we did not receive and that continues. So that kind of agency city and state coordination was critical and, clearly, there are many, many lessons learned. I just, you know, hope that hospitals, regardless of whether they're public or voluntary, that we could work more seamlessly in the future. So we don't see so much inequity as we did during the pandemic. And I want to commend you also for your work. Just for one very small example was the COVID helpline and the thousands and thousands of New Yorkers that you responded to, when they called in, you did that on your own. Health and Hospitals did along with the

support from some of your agency colleagues and I want to thank you for that. That was critical in answering questions and making sure that people stood out of the hospital if they could stay home and recover safely. So with that, I'm going to turn it over to my colleagues. Thank you for answering my questions. I guess I'll turn it over to committee counsel, though I know-- I think Council member Levine is first in the stack.

COMMITTEE COUNSEL: I'm now going to be calling on Council members in the order they have used the zoom raise hand function. As a reminder, if you would like to ask a question, please use the zoom raise hand function now. First, we will turn to Council member Levine.

SERGEANT-AT-ARMS: Time starts now.

COUNCIL MEMBER LEVINE: Thank you so much. Thanks, Chair Rivera, for your great work today and your leadership throughout this crisis and I want to echo your words about how critical our H&H system has been over this pandemic. I don't even want to think about what it would've been like to go through this without the 11 acute car hospitals that we have in our public system and the amazing, amazing nurses,

doctors, techs, frontline staff, the administrative folks that undoubtedly saved countless lives during this very difficult time and continue to do and we continue to rely on you. I also want to thank Jackie Brady, whose leadership has now spanned two different phases of the pandemic and two very critical portfolios. And, lastly, a shoutout to what I think are some unsung heroes which are the DOHMH warehouse staff. I know that assistant commissioner Dave Star is here, but you guys have done a lot of round the clock work to help keep our supply chain going and that, by necessity, has to be done out of sight. There were actually security reasons for that, but we're grateful for your efforts. I want to start by asking about reports we're seeing about, yet again, eight months into this pandemic, a national shortage of particularly N95 masks. It's just insane that the federal government hasn't got it together on this, but with cases surging in a lot of other states, and so demand is really high. Apparently, there are very short stockpiles in some of the most affected states now from Michigan. I've seen particular reports where stockpiles in hospitals are one week or less and it seems like what the federal government was

doing now is prioritizing distribution away from places like New York which are trying build up the stockpile as we have to towards states which are in crisis right now. And so, I'm not sure if that would be a question for you, Dr. Katz, but are we impacted by national supply chain problems? Are we competing with other state with that context? How secure are you feeling at our supply at this point?

DR. MITCHELL KATZ: I feel good about the H&H supply because we put in orders and they keep rolling in. So, I'm not particularly worried about H&H, but I think you raise a great question and I'm interested in what, Deanne, you're seeing across the system.

COMMISSIONER CRISWELL: Thank you, Mitch. So, as these states are now starting to see peak levels like we saw in the early days of this pandemic, I think they're going through some of the same learning curves that we went through on how best to utilize their scarce supplies that they had and that's just purely an assumption, in my opinion. But I think for where New York City stands right now with the PPE service center that we put in place and the vendor that we have hired. We've done a lot of work

for, again-- and all of the hospitals have built their own supplies and the city has built a 90 day supply, as well, but the vendor has also been able to diversify where we are getting our PPE from and so we're not limited as much as we were in the beginning by just having one source for obtaining PPE which will put us in a better position if we do start to use it at the levels we were before and have to continue to replace it. And so we are in a much better place than we were then and it's sad to hear that some of the other states are having to go through this now. But I think, you know, by having this diversification and this new PPE service center. It sets us up well for the continued rise that we are continuing to see.

COUNCIL MEMBER LEVINE: That's good to hear. Please keep us posted if and when we, once again, we start to bump up against the national shortages. Dr. Katz, I know that one positive thing that has come out of the extremely difficult experiences of the spring for our city is that we have learned a lot about this disease, about how to care for people with COVID-19--

SERGEANT-AT-ARMS: Time expired.

COUNCIL MEMBER LEVINE: and how to operate a hospital system in the face of this pandemic. Could you talk to us about some of the lessons learned about ways, if there are any, that that will advantage us as we hit a second wave.

DR. MITCHELL KATZ: Thank you, Council member. Yeah. I think there are very important lessons and I feel like, when you go through something horrible, you should at least learn something that would help you in the future. And so, we're making a lot of physical changes in the hospital that, I think, will make a difference regardless of what the future illnesses are. For example, we discovered that we had a lot of rooms where there was no window or glass door so that the only way you could, you know, know what was going on with the patient is to have the door open, but when you have infectious diseases, you don't want the door open. You want the door closed. And so, now we have changed all those rooms out and we put in glass windows in the wall or a glass door instead of a wood door so that we can see. We're putting into all of our rooms now a monitor for sounds and video because, if you think about the old model of hospitals,

patient rings call bell, nurse walks down long hallway to find out what it is that the patient needs. Right? And then he or she may have to go back to go get it. So while that's not a very good system regardless, so let's figure out, you know, what the patient needs from the nurse's station so he or she can bring it. We learned a lot about how to use tablets to allow families to talk to one another during the time that we weren't allowed to have visitors. But what we have also learned is, wow, sometimes people were allowing visitors, but people's family was across the country. Why can't we do this all of the time? Why can't we always have tablets available so that people can talk to family members? So we've had now family meetings about addressing end of life issues where we include family members who are across the country. I mean, we could've always done that, but somehow it never fully occurred to us. And then, in the transferring policy, the way we did it the first time learning is we grew ICU everywhere the patients arrived. And when we got too full, we transferred. We're going to do it, if there is a second wave-- I should say, right at the moment we can accommodate several hundred patients without

developing any new ICU. But if we do hit that second wave, again, what we will do is we will stabilize patient and transfer them before we run out of space in our ICUs so that every hospital will have available ICU beds for the patients who came into the emergency department. One of the things that made that transfer so difficult and why even with the states, you know, good attempts to help us, we had challenges. It's that all of our beds were full and so the patients that needed transfer were all in the emergency room, which made them unstable. So, instead, what we want to do now is patients come in through the emergency room. We will stabilize them and bring them to the ICU. If we see that the ICU and that hospital is getting your full, we will then transfer ICU patients who are on stable vent settings to another hospital, thereby, always maintaining ICU beds for the patient who was in the emergency department who was so unstable that they can't get into the ambulance. Those, for us, where the big lessons that would enable us to do a better job in the future.

COUNCIL MEMBER LEVINE: Well, that's all encouraging. Dr. Katz, I too often hear from people

that understand that, while the number cases are increasing in New York City, they have a misconception that the virus is no longer deadly, that we are only seeing mild cases now, and could you clarify for us what you are seeing coming into your hospitals now and the extent to which New Yorkers still need to treat this as a deadly disease?

DR. MITCHELL KATZ: Well, if it were not a deadly disease, I wouldn't have lost my father-in-law last month, so we know that this is still a very deadly disease. We always want to be honest and transparent, and things are better in the sense that we are better at caring for sick patients. Some of it is what we were talking about before. Recognizing that intubation is not always the right answer. Some of it is the benefit of the steroid, anti-coagulation to prevent clots, rapid dialysis for patients who go into renal failure. No question that we are better and that mortality rates across the country have dropped because of what was learned in New York and the other areas in the beginning. But equally true, in New York State, 19 people died yesterday due to COVID, so this remains, you know, a tremendous risk to people. It is hard, I think-- you know, and this

may be human nature. Most people-- It's still true that 80 percent of people that get infected have zero symptoms at all. And I think that makes it hard for people to understand, but you don't know who is going to be the one percent of people who are going to die of this disease. And so I think we have to keep making it clear that, yes, things are better and, yes, most people who get COVID will be fine. But one percent of them are going to die and many people will have long term side effects, the so-called long haulers who are still struggling to this day from March with neurologic symptom, persistent fatigue, shortness of breath. Right? Even if you survive, it doesn't mean that that is an easy illness to transcend.

COUNCIL MEMBER LEVINE: Thank you, Dr. Katz. You all set up a COVID hotline in March which was a source of information for general questions, but was also staffed by clinicians. And I wondered if you could tell us is that hotline still up and running? Could you just describe its operation and staffing at this point? And what kind of calls are coming in?

DR. MITCHELL KATZ: Yeah. It is still running, although was don't run it 24 hours a day anymore. It's not necessary, but we still get calls. We still direct people. It always had the advantage that Health and Hospitals has excellent language line capabilities. We can easily connect through our language vendor for over 100 languages, people are still coming. Right now, the major questions about our way to get tested, you know, how long do I have to quarantine? You know, do I need to be quarantined? Do I need to test? So, the nature of the questions has changed, but it was, clearly, one of the critical things that got us through that time and it's just that the hospitals were overrun. It's that, given that the hospitals were full of infected people, imagine how much worse it would have all been if we had sent all of those people, only some of whom had COVID, into the crowded waiting groups. Like we would've created our own multi-infectious event. So, that was definitely one of the things that saved us.

COUNCIL MEMBER LEVINE: Absolutely. And, finally, just a question for DOHMH and, I guess that would be assistant commissioner Kennelly. You're responsible for public messaging. DOHMH has really

been in charge of the subway ads and the PSAs on TV and al that. And I wondered if you could tell us the extent to which that campaign is ongoing? Do you have a way of assessing how effective it is? And maybe a word about multi-lingual communication so that we reach every sector of the city.

MAURA KENNELLY: Thank you for your question, Council member Levine. Yes. We have been running citywide media campaigns since February, adjusting our messaging as needed, as we learned more about the virus, as directives to New Yorkers and guidance changed. Our campaigns were designed in terms of our placement to saturate the market and we were given the resources to do so. And we really attempted to ensure that New Yorkers were receiving these messages on multiple platforms. So, TV, [inaudible 01:12:53], streaming platforms like Hulu, out of home placement, including bus shelters, subways, grocery stores. Things like that. And then across all digital and social platforms. In addition, we translated all of our materials into 25 languages and our media campaigns were available in the top 13 languages. They were on in language TV stations, radio stations, newspapers. Really, again,

trying to saturate the market and reach as many New Yorkers as possible. The campaigns continue. We've evolved, again, as the messaging evolved. We're working closely with out T2 colleagues on messaging around get testing, as well, and we will have new messaging [inaudible 01:13:50] winter. We need New Yorkers to continue to adhere to the public health guidance. It's what going to help us move through the next phase of the pandemic.

COUNCIL MEMBER LEVINE: Excellent. Thank you very much for that and thanks to all our panel and thanks again to you, Chair Rivera. I'll send it back to you.

CHAIRPERSON RIVERA: Thank you so much. I want to acknowledge we been joined by Council member Eugene and I do want to move on to my other colleagues that are here and I see that Council member Ayala has a question.

SERGEANT-AT-ARMS: Time starts now.

COUNCIL MEMBER AYALA: Thank you. Good morning, everyone. Thank you. I mean, this is been great and I just want to reiterate that I am so proud of Health and Hospitals and all of the work that was done to really control this pandemic. And, you know,

I am extremely proud of Metropolitan Hospital that's in my district. I think that they did a, you know, spectacular job. I was actually there a couple days ago getting my rapid COVID testing. I had my results in an hour and a half. It was awesome. So I've been encouraging others to do the same. To go in and get it done. It's very easy. Very simple. Painless. The results are in within, you know, a couple hours. So, thank you for that. My concern, however, is really primarily related to the psychiatric beds that were transitioned over to COVID beds. I'm not sure what-- you know, I haven't been able to get clarity about what that transition looked like, how many patents were lost and have we regained those beds now that there is some stability?

DR. MITCHELL KATZ: I'll start and I want to thank you, Councilwoman, for all your support during that time. You sent me a lot of, you know, encouraging text to get through and I will also remind you Metropolitan had some of the early successes of a woman who was over 90 years old who had been on the ventilator and had gotten off it. The staff all applauded her. I still remember the image of her leaving the hospital with all of these

nurse applauding and it was that kind of thing that got us through those horrible, horrible times. We did lose some beds, although I'll point out that Health and Hospitals, to my knowledge, is the only facility anywhere the created a COVID psychiatric ward. We had that at Bellevue so that we could-- we were the ones accepting when other hospitals said that they couldn't accommodate someone who needs acute hospitalization because they were COVID positive. We took those admissions no matter where they came from because we were the only ones capable of doing that and that was stood up, you know, at Bellevue, basically, in a day. We moved a lot of things around and I don't have an exact count, but when this is all done, I think we're going to have more psych beds than we used to have, in part because other hospitals continue to decrease their investments in psychiatric beds. Psychiatry beds do not pay well. We can't make it on Medicaid. We can't break even no matter how efficient you are. It's just not possible. But we'll keep doing it because we have your support and that's where the mission-driven people, thanks to the city for providing us the subsidy to be able to do it. But

I'll try to get you exact numbers of where we are, but the goal is to be higher when we're all done, not lower.

COUNCIL MEMBER AYALA: No. I really appreciate that because I'm concerned about, you know, the mental health of the city and, you know, what that's going to look like a year from now because I think that we're all kind of still high on adrenaline and we haven't, you know, really allowed ourselves the opportunity to really process everything that we've been through because we're still kind of in the midst of it. And so I'm really concerned about, you know, the coming year and what that looks like and I want to ensure that we're prepared to deal with, you know, a mental health crisis. Right? Because they're interrelated. So thank you so much for, you know, all of your work and, you know, you were such a source of inspiration and help throughout the pandemic both, you know, personally and professionally and I thank you for always being--

DR. MITCHELL KATZ: Thank you.

COUNCIL MEMBER AYALA: a good human being. Thank you.

DR. MITCHELL KATZ: Thank you.

COMMITTEE COUNSEL: Thank you, Council member. Next, we will be moving to Council member Eugene for questions.

SERGEANT-AT-ARMS: Time starts now.

CHAIRPERSON RIVERA: Council member Eugene here? In the meantime, hopefully he'll come back to his desk. I just want to commend Health and Hospitals for what you've done for patients in need of psychiatric care and that goal of having more psych beds for individuals, as well as beds for those with COVID. You are constantly providing a disproportionate amount of psyche care even before the COVID-19 pandemic. And I agree, as other hospitals are closing them, you willing to take that on is just another testament to your mission and I realize they do not pay well and I wish that more people were driven-- more institutions were driven by what's most important, which is providing care for people and not providing care for profit. So I do thank you for that always. Always. Always.

DR. MITCHELL KATZ: Thank you.

CHAIRPERSON RIVERA: Is Council member Eugene here? Because I did want to have him be the

last round of questions and then let you all get back to your fulltime jobs. All right. Well, unfortunately, I guess he just stepped away. I want to just thank you all for coming in and answering our questions, for being true public servants, caring so much for New York City. I know Dr. Katz didn't know what would be before us. And to you, Deputy Executive Director, to you, Commissioner, I just want to thank you for all that you did. It really does mean a lot to all of us to know that you're still with us. We can send you the questions that, maybe Council member Eugene had. And I know that we also discussed some of those number that I mentioned in terms of how many patients went to the alternative care sites from H&H and anything else my colleagues would've asked, we would appreciate that feedback. Those responses. And just thank you. Thank you. Thank you. Thank you.

DR. MITCHELL KATZ: Thank you. Thanks for supporting us. We really appreciate it.

COMMITTEE COUNSEL: Thank you all for your testimony. At this point, we have concluded administration testimony and we will now be turning to public testimony. I'd like to remind everyone

that we will be calling on individuals one by one to testify. Each panelist will be given three minutes to speak. For panelists, after I call your name, a member of our staff will unmute you. Please wait a brief moment for the Sergeant-at-arms to announce that you may begin before beginning your testimony. Council members who have questions for a particular panelist should use the raise hand function in Zoom and I will call on you after the panel has completed their testimony in the order in which you have raised your hand. I would now like to welcome our first panelist. Jenna Mandel Ricci. You may begin your testimony when you are ready.

SERGEANT-AT-ARMS: Time starts now.

JENNA MANDEL RICCI: Good morning, Chair Rivera, Chair Torres, and other members of the city Council. My name is Jenna Mandel Ricci. I am representing the Greater New York Hospital Association. GNYHA is proud to support the city's 55 hospitals serving as a bridge between them at all levels of government during emergency response, including the ongoing COVID 19 pandemic response. GNYHA and our members believe healthcare is a human right and do everything possible to make that a

reality. New York's response to the spring COVID 19 patient surge necessitated the largest deployment of healthcare resources in US history. New York's health system bent, but it did not break. In March, to reach the unprecedented volume of patients, hospitals rapidly converted existing beds and created new beds using nontraditional spaces such as lobbies and conference rooms, as well as developing alternate care sites outside of the hospital walls. Hospitals redeployed existing staff and incorporated agency staff. Hospitals also recruited volunteers from the city's Medical Reserve Corps and the states volunteer portal and used out-of-state volunteers. Acquiring PPE was challenging, given the increased demand and breakdowns in the global supply chain. GNYHA worked with the city, as you have heard, to establish a formal resource request process for hospitals, as well as allocation methodologies for PPE and, later, ventilators. DOHMH and New York City Emergency Management began weekly supply deliveries, which you just heard about, to every hospital starting the week of March 23rd and, soon after, but acquired ventilators acquired from state and federal stockpiles. Using day-to-day processes as the

foundation, hospitals and health systems frequently transferred patients from hospitals experiencing high patient volumes to ones with greater capacity. Now, I would like to discuss preparations for future waves. The importance of adherence to public health measures cannot be overstated. Maintaining low infection rates was critical to preserving hospital resources. Hospitals are working with the city and state to address micro-clusters as they appear in order to blunt a second wave that could coincide with the flu season. Over the summer, New York State issued a regulation requiring all hospitals to develop a 90 day stockpile of PPE. New York City's newly established PPE and ventilator stockpile are an important complement to this effort. With the lessons of the spring surge in mind, hospitals have been improving their search plans. Hospitals are determined to maintain normal operations wall also meeting the needs of COVID 19 patients. Hospitals plan to use phased search plans, adding beds as needed. GNYHA has been working to advance strategies designed to prevent a single hospital from becoming overwhelmed with patients. The hospital community is also working with the city and state to develop and

implement a vaccine distribution and implementation plans. Hospitals are fighting for their very survival. Every hospital in New York State will lose money this year.

SERGEANT-AT-ARMS: Time expired.

JENNA MANDEL RICCI: May I continue just another moment? Great.

CHAIRPERSON RIVERA: Of course.

JENNA MANDEL RICCI: Thank you. GNYHA, like the city and state, is advocating in Washington DC for state and local funding to protect New York's healthcare system. Without substantial relief, the state may not be able to maintain the hundred million dollars in direct subsidies to safety net hospitals and may be forced to slash the Medicaid budget by 20 to 30 percent. Thank you for the opportunity to testify on this important issue. New York hospitals will continue their mission providing the highest quality care when patients are in need and we are proud to help them achieve that goal. Thank you very much.

CHAIRPERSON RIVERA: Thank you, Ms. Mandel. I saw you at the beginning of the hearing, so I think you have been here the whole time and I

want to thank you for waiting. I asked the question of the administration on PPE distribution and the impact on patient utilization. In June 2020, this Committee and Hospitals had a hearing on hospital reopening and, during the hearing, discussed the impact COVID had on access to care, including vaccinations, dental care, and cancer related care and, as of today, what trends are hospitals seeing with respect to outpatient, inpatient, and emergency department utilization?

JENNA MANDEL RICCI: Thank you for that question, Chair Rivera. I don't have the exact numbers in front of me and, maybe, perhaps Dr. Katz can weigh into. We are seeing volumes return, but I don't think they are fully at their pre-COVID levels yet. There is a lot of work being done, as all the hospitals and healthcare systems were reopening, to proactively reach out to patients out of great concern that they were not receiving the care that they needed and the preventative care that they needed. So that work is ongoing.

CHAIRPERSON RIVERA: I also asked about the-- how the New York City Emergency Management coordinated medical surge staffing. And can you

discuss how hospitals coordinated with emergency management on coordinating medical surge staffing and the application process and paperwork?

JENNA MANDEL RICCI: So, during the COVID patient surge in March and April, hospitals and health systems were trying to access-- using a number of different strategies to access surge staff. And you heard a little bit about this in my testimony and did the earlier testimony. One way was redeploying staff that they already had. So, for example, taking staff from ambulatory care sites or primary care sites and doing the necessary training and redeploying them into the hospitals. There were also contracts with staffing agencies that allowed them to bring staff in and hospitals did take advantage of the long-standing Medical Reserve Corps that the city Health Department runs and were able to access staff through that mechanism. New York State stood up a staffing portal and then, of course, because we were at the very beginning of the wave, we had an unbelievable outpouring of support from out-of-state providers and that also helped. And New York City Emergency Management, huge applause to them and the rest of the city for putting together a

really robust program that allowed flights and hotels that enabled those out-of-state volunteers to come in and assist. That was an enormous help to come in and assist. That was an enormous help. And the issue of staffing is something that continues and is an area of immense focus for all of the hospitals and health systems across the city to ensure that they have the staff that they need if we are to experience a resurgence or second wave. So, that is an issue that everyone is been very focused on. Both the hospitals and the health systems and the various agencies.

CHAIRPERSON RIVERA: Yeah. It was very much all hands on deck at the peak of the pandemic, and I know people who had also been retired or who otherwise had not necessarily been trained in related medicine were called to help. Who was responsible for ensuring that new staff received necessary critical training? The city agencies assisted what this or was it up to individual hospitals?

JENNA MANDEL RICCI: So, all hospitals must have what are called emergency credentialing processes and procedures and there is a whole host of work that goes into being prepared for any kind of emergency. And, obviously, COVID 19 is a very

different kind of emergency they had folks have experienced previously, but there were already existing processes and procedures to credential staff that normally don't work within the hospitals to work within the hospital. And so, it is really the human resources departments and other departments within the hospitals that take on that responsibility and it differs in what has to happen based on whether you are an allied health provider, a nurse, physician. But all of those folks were brought in-- first of all, there was the whole process to understand what their experience and what their licensure and credentials were before being brought in and then, as they were brought in, they had to have all of that verified and checked. They had to be oriented and then, of course, if you have someone who is not familiar with your operations, there is a supervisory sort of structure that is put in place as they are working to make sure that they can work safely and effectively within your institution.

CHAIRPERSON RIVERA: In terms of patient transfers, I asked Health and Hospitals and the administration about an investigation by the Wall Street Journal and the city struggling to receive

assistance from the state to set up this centralized hub to implement patient transfers between hospitals and, during the pandemic, I did see during one of Governor Cuomo's press conference is, representatives from the Greater New York Hospital Association sitting at desk discussing how we were going to work as one system. And I want to ask what exactly happened with that centralized hub? How did it assist with patient transfers and how were those patient transfers used to assist with patient caseload considering the disproportionate impact this pandemic had on our public hospital system throughout the entirety of the last few months?

JENNA MANDEL RICCI: So, I think in thinking about the question of patient transfers, it is important to recognize that patient transfers happen day to day in the healthcare system. So, whether you are an independent hospital or you are part of the health system, there are already processes and structures in place that, if you end up with a patient that you can't appropriately care for given what their condition is and given what services you have at the hospital, they are already day-to-day processes. And so, as the case is Rose in the

spring, hospitals relied on those day-to-day processes. So, independent hospitals already have sort of routine transfer partners that they work with and then you heard Dr. Katz, for example, talk about within the New York City public hospital system how transfers occurred. That happened in all of the large health systems within the city, whether it was New York Presbyterian, North well-- as we saw surges in cases in Queens and many-- all of the hospitals located in Queens became very full of patients. So, there was constant efforts to try and relieve that pressure on those hospitals in order to provide high-quality care to those patients, as well as ensure that those hospitals were ready to receive any new patients that were coming in. So, that was going on as a backdrop. And then, as issues arose, we did play a role because we have strong working relationships with all of the health systems in all of the city. So, for example, we had a very unique relationship with the Veterans Administration which allowed us to put small numbers of patients each day into some of their hospitals. So, we actually worked as the clearinghouse and used existing data sources to understand which of our hospitals may need that

relief valve and we actually worked through those transfers with the hospital that needed to send patients into the VA hospitals that were ready to accept them. We also worked closely with colleagues at the State Department of Health to be looking at the numbers and understand who needed to go in. There was a lot of data that went into how what hospitals were being approached about transfers for us to understand what hospitals were likely going to need to transfer and, also, as you heard, I believe either Dr. Katz or Commissioner Criswell talked about many of the Department of Defense providers were actually pushed into hospitals based on where the needs were greatest. I hope that answers at least part of your question.

CHAIRPERSON RIVERA: Sure. I do know that the Department of Defense was certainly involved. And, again, we received assistance from across the country, which we are eternally grateful for that we have tried to repay that debt as well as we could. I guess what I want to know is, you know, our cities public hospital system, other safety net hospitals, serve a majority of the cities under insured population and many of their sites are

located in the communities that were hardest hit by the pandemic and the New York Times reported that the use hospitals could have benefited from additional resources as they were clearly caring for some of the patients that were most in need during this time. So, did the administration prioritize ensuring our public hospitals and safety net hospitals received the PPE and equipment they needed? And, I guess, what I mean by the administration it is also kind of in your capacity, the Greater New York Hospital Association coordination? How did voluntary hospitals provide assistance to our public hospitals, particularly those disproportionately impacted by COVID 19. And I will give you an example. Did voluntary hospitals assist with patient transfers taking on more patients from safety net and public hospitals and what about the additional staff that we mentioned briefly?

JENNA MANDEL RICCI: So, I think it is important to recognize that, during the search, all of the hospitals across the city, they weren't all impacted equally, but hospitals everywhere were managing incredible volumes of patients that had never been seen before. And what we did-- and we

just like throughout the response, we worked very, very hard to make sure that all of our members, which includes all of the H&H facilities, as well as all of the other hospitals waited New York City, we were doing our best to ensure that they all had what they needed in order to meet the needs of the patient that were within their doors. And they were all struggling. Every hospital was struggling to keep up to the demand. So, I think the PPE example is great. We really feel so proud of the work that we did with Jackie Bray at City Hall and with Dave Starr and his team at the city Health Department and H&H to make sure that every hospital got the PPE that it needed to make sure that the ventilators were allocated, as well. You know, I can't speak-- there was so much going on. I can't speak directly to which hospital helped which other hospital. I do know that there is an was very much a spirit of collaboration. I know that neighbors help neighbors. So, while you may be part of a health system, if you are located next door to Elmhurst and you are at a Mount Sinai facility, you just helped each other out because that is what neighbors do. So, I think there was a lot of folks calling folks that they do and, oh, we need a tiny

bit more of this to get us through until the next weekly delivery. So I think there was a lot of that going on. And, again, I think with patient transfers, because it is very complex, as Dr. Katz alluded to, generally those transfers happened within the health system because there are electronic health records, there are provider relationships, there are ambulance contracts. All of that, that make it much easier and more efficient to transfer within a health system, but that doesn't mean that transfers didn't happen across health systems. They just, I don't believe, happened at high numbers. But I do think that there was absolutely a spirit of collaboration amongst all the hospitals and, frankly, were doing their best to manage the crush of patients that they were working to serve.

CHAIRPERSON RIVERA: Paul, thank you for your needs are. I think we are going to hear from some advocates, policy experts, as well as, potentially, some of the amazing staff that were inside of these hospitals witnessing this collaboration. So, I'm interested in getting their feedback and I encourage you and everyone he was here from the administration to stay in here some of what

I think will be very, very honest feedback and real solutions of how we can, of course, do better and prepare for anything coming our way. So, we've got to just-- Yes. I want to thank you for your testimony. I think that is it for my questions. I don't think I see any of my colleagues here to ask anything. So, with that, I will let you go and move on to some of my--

JENNA MANDEL RICCI: Thank you.

CHAIRPERSON RIVERA: friends and allies.

COMMITTEE COUNSEL: Thank you for your testimony. We will now be moving on to our next public panel. In order of speaking, we will have Elizabeth Benjamin followed by Christopher Schuller followed by Anthony Feliciano. Elizabeth Benjamin, you may begin when you are ready.

SERGEANT-AT-ARMS: Time starts now.

ELIZABETH BENJAMIN: Thank you. I want to first of all thank the city Council for having this important hearing. The Community Service Society is 175-- and, specifically, you Council member Rivera for hanging in there is the only one left standing. I really want to-- you know,

Community Service Society is a 175-year-old organization that works on improving the lives of working people. I really want to start out my testimony by saluting Health and Hospitals in the private and voluntary system and all of the healthcare workers that work in these facilities. This has been a very tough time for folks and, you know, their work and their sacrifice is so, you know, we so appreciate that, on behalf of all New Yorkers. And I just can't overstate that enough. I really wanted to go into the question of how COVID has had a disparate impact on people of color. I think that was the line of questioning that was really important that you had started, Councilwoman Rivera. And I just want to emphasize that we know that in, New York City, COVID has had twice this harsh impact on people of color in terms of morbidity and mortality around the state. It's four times disparate impact on people of color and that is related to, you know, who our essential workers, social determinants of health such as quality of housing, type of housing, doubling up, insurance. The ability to access insurance. Food security. But what I really want to focus my testimony on is not a social determinants of health

because, you know, these disparities are social construction, but social constructions are the result of concrete policy decision. In New York State has made a series of policy decisions and really unfair allocation of healthcare resources that have, in fact, exacerbated the disparities in the COVID pandemic. So, in New York State, 20 years ago had 75,000 beds. Now we have 50. There are 25,000 missing beds. Where are the missing beds? Let's just look at Queens. Around Elmhurst, there are four closed hospitals and so, of course, Elmhurst really got, you know, overwhelmed. And, quite frankly, we have 6.4 beds per thousand people in Manhattan and yet we only have 1.5 beds per thousand people in Queens. Similar disparities are experienced in the Bronx, Brooklyn, and Staten Island. And what is happening with COVID? Well, there is 34,000-- 34 cases per thousand in Queens and only 21 cases per thousand in Manhattan. So, there is no greater health need in Manhattan, there is only greater health resources in Manhattan. In these resource allocations are by design and the design started in the 90s when we deregulated our hospital rate system, so we went from--

SERGEANT-AT-ARMS: Time expired.

ELIZABETH BENJAMIN: Time's up? Sorry?

CHAIRPERSON RIVERA: Please continue. We do have a timer, but I want you to complete your testimony--

ELIZABETH BENJAMIN: I think I've got two more minutes, if that's okay.

CHAIRPERSON RIVERA: That's fine. Please. Absolutely.

ELIZABETH BENJAMIN: So, we deregulated our-- so, financing decisions like this: we deregulated our hospital rate setting system which protected and resourced our safety net hospitals. We eliminated and, essentially, eviscerated any kind of health planning that was done on a regional basis to our health system agencies and now we have private and voluntary dominated Hospital Planning Council and Health Planning Council that, basically, rubberstamps, you know, mergers and acquisitions of wealthy institutions and closures of poor ones. And then, finally, we wasted about in excess of 13 billion in our indigent care pool over the last 20 years that we spent on rich hospitals and not targeted to our safety net hospitals like our very

own beloved that Health and Hospital system in New York City. The last thing I want to say on financing is that the Cares Act made this all much worse. The Cares Act, Health and Hospitals basically got about 100 million dollars so far for hospital. New York Presbyterian got 631 million dollars. So that's a six to one disparity. Which hospital overpour hospital. NYU 427 million. Mount Sinai 200 million, so I don't know what they did wrong. Anyway, so they only have a two to one disparity over Health and Hospitals. And then the nonprofit hospitals in our city are, you know, basically, go around suing people. They are suing 6000 people right now. They are not behaving like charities. Some of them charge nine percent interest which is a commercial interest rate and not a charitable interest rate which, in fact, they get when they get loans from the government. So, there are real problems. We have some solutions. One solution is your very own bill, Councilwoman Rivera, intro 1674 which would establish a hospital patient advocate. Maybe we could get some answers like how many COVID patients were handled by hospitals? How does that lineup with that Cares Act funding was allocated? I think that is the most

important question that this body could get the answer to. The second thing is that maybe it's time to start investigating, you know, property tax exemptions or maybe we should like right size that so that we get more property tax exemptions to safety net hospitals and a little less tax exemptions to the super rich hospitals that could, maybe, afford to maybe pay some taxes. Or zoning questions. Why do we need a 40 floor tower for North Shore-- North well to have the upper East side of Manhattan when we clearly don't need more hospital beds? Why not put that 44 tower around Queens? Somewhere in Queens? I think there are four missing hospitals. There certainly a need for more beds in Queens should we have more pandemics in the future. Then, finally, I think we really need to resourced community groups to be able to help patients who are being pursued very aggressively by these hospitals and other providers for medical debt. Our medical debt burden in New York City, quite large. There are racial disparities in who owes medical debt and I think we really need to resourced groups to help those folks. I'm going to stop there because I went way over time and I apologize to the Sergeant-at-arms for doing so.

CHAIRPERSON RIVERA: It's okay. I'm going to ask a question after this panel for you particularly. Yes, we do have a timer, but I never want anyone to think that they cannot finish the thought or the important points that they want to make. So, to the next panelist. Thank you.

COMMITTEE COUNSEL: Thank you for your testimony. Next we will be hearing from Christopher Schuller. You may begin when you are ready.

SERGEANT-AT-ARMS: Time starts now.

CHRISTOPHER SCHUYLER: People with disabilities, which include people 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 mistakes made earlier this year to improve the care given to people with disabilities before a potentially devastating second wave hits. Good morning, Chair Rivera, and members of the committee. I slipped in just before noon. My name is Christopher Schuyler. I'm a senior staff attorney for New York Lawyers for the Public Interest with the disability justice program. I am a person who

stutters. I also want to draw attention and thank Dr. Katz and his team for their leadership during this very challenging time. I'm part of [inaudible 01:48:00] part of the coalition of advocates and stakeholders who work closely with Dr. Katz and I appreciate all his leadership. My testimony today will cover issues that people with disabilities would face at city hospitals during the COVID 19 pandemic, as well as recommendations to improve care delivered to people with disabilities going forward. Approximately 1 million New Yorkers self-identify as people with disabilities. While disability alone may not increase the threat of COVID 19, though emerging resource suggest otherwise. Many with disabilities also had underlying conditions which are known to increase the risk of contracting COVID-19. In fact, adults with disabilities are three times more likely than those without disabilities to have heart disease, stroke, diabetes, or cancer. 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. Moreover, this virus, generally, have been most devastating to people

belonging to racial minorities as Latinos and African Americans are three times more likely to be infected than white people. New York state hospitals anticipate losing 25 billion through April of 2021. Hospitals should be exempt from budget cuts. Public city hospitals are already struggling, as we testified earlier today. Much more so than their private counterparts. They bear most of the weight of the poor and working class New Yorkers. Critically, the hospital services that should be most support are those supporting the most vulnerable populations, including people with disabilities.

SERGEANT-AT-ARMS: Time.

CHRISTOPHER SCHUYLER: I see my time is up and I apologize that. I'll try to breeze through some of my main points and hit my recommendations at the bottom of my document. And for anybody, I'll admit my written testimony which he will get a look at in more detail than what I have to say. So, to issues affecting people with disabilities seeking medical care at city hospitals during the first wave of the COVID 19 pandemic, the threat of rationing 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 for people with disabilities who often need higher levels of care than people without disabilities. The concern was that medical providers would make determinations for care-- to care for others less needy than them. To aid medical providers in making such determinations, New York needs clear and expansive crisis standards of care. Currently, New York's CSC, which was enacted in 2015, covers only the narrow issue of until later allocation and does so in a way that is deeply troubling for people with disabilities. Incredibly, the existing ventilator guidelines indicate that people with disabilities using a ventilator in everyday life could, when seeking acute care services during a scarcity crisis, have their leader removed and get into a person with a higher likelihood of survival. The ventilators, of course, are not the only form of essential care and New York also needs to pass guidelines that ensure that people with disabilities, that they will receive equal access to other respiratory therapies, medications, critical care beds, and staff during crisis. Currently, medical providers are without uniform

guidance in these matters and are left in the unenviable position of making case-by-case determination. While these determinations are supposedly neutral and data-driven and intended to produce objective, unbiased medical decisions and practice subjectivity based on bias and misinformation about the quality of life and that people with disabilities plays a significant role. 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, as well as other types of essential care. I want to say a few words about restrictive visitor policies. So, in the effort to control the spread of COVID 19 this past spring, city hospitals instituted strict no visitor policies. These policies, in some cases, negatively impacted people with disabilities who often rely on family members, interpreters, and designated caregivers to aid in their effective communication with medical providers. Without the assistance of visitors, many people with disabilities, including those with intellectual and developmental disabilities were unable to make

informed medical decision and were thus denied equal access to care. 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. There issues concerning inadequate communication with people who are deaf, hard of hearing, deaf blind, as well as those needing language access assistance. So, during the first wave, hospitals overwhelmed by the crisis often failed to divide access to American Sign Language interpreters and video remote interpretation. To make matters worse, masks without see through plastic portions make lip reading impossible. These challenges cannot be used as justification for lower level medical care. Hospitals need to address these shortcomings now to improve their processes for dealing with them in the future. There's also a need for exceptions to universal mask wearing policies. While universal mask wearing policies are the prevailing method of control of spread of COVID 19, certain people with disabilities either cannot wear masks for long periods of time or at all. The

disability laws require-- ensure equal access of healthcare services and, when necessary, to provide accommodation even for people with disabilities requiring conflicting accommodations. I just have one last kind of issue I want to bring to light and then I will list our recommendations for improved care. So, the last issue is the inaccessibility of telemedicine for certain people with disabilities. Telemedicine is an example of [inaudible 01:55:05] driving inhibition and is a valuable tool in how to control the spread of COVID-19 and telemedicine experience persistent growth since earlier this year. However, certain people with disabilities are unable to benefit from this healthcare option and a large percentage of people with disabilities live below the poverty line without baseline technology devices and broadband internet and that platform is not useful. Also, certain people with disabilities may not possess a level of technology literacy necessary to utilize telemedicine. Additionally, people with disability and communication impairments may not be able to use the technology without the assistance of an interpreter on hand. Lastly, the lack of in person connection between medical providers and

people with disability risk the delivery of lower levels of care. Our recommendations are we encourage that the New York State Legislature-- we would like the New York City Council to encourage the New York City Legislature to revise its crisis standards of care pertaining to ventilator rationing, clarifying that people with disabilities currently using ventilators will not be taken off their ventilators when seeking acute care. Additionally, to broaden the CSC to ensure people with disabilities that they will receive equal access to respiratory therapies, medications, critical care beds, and staff during times of resource scarcity. We also would encourage the revision of city hospital visitor restriction guidelines with input from disability community stakeholders to ensure the rights of people with disabilities, equal access to medical care. We would like the training of medical providers at city hospitals mandated to recognize implicit bias as it pertains to people with disabilities. Unacknowledged bias has demonstrated to contribute to worse health outcomes of people with disabilities. We also would like to encourage the city Council to 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 from the COVID 19 pandemic that is thereby lessening patients and family members of their rights to hold hospitals accountable. And, lastly, we would like to recommend appropriate funding reallocated and resources to improving telehealth experiences for people with disabilities. Thank you for the opportunity to testify about these key issues which have negatively impacted access to medical care for people with disabilities during the COVID 19 pandemic. Please feel free to discuss any further-- discuss with me further. And I appreciate you giving me a few extra minutes to get those recommendations out. Thank you.

CHAIRPERSON RIVERA: Thank you. And I know I have legislation, Intro 2017 which will call for clarity and communication on visitation policies to ensure equal access to care, which is just one small point that you made, so I appreciate your testimony and, Harbani, I know we have someone else on the panel. Thank you so much.

COMMITTEE COUNSEL: Thank you for your testimony. I would now like to welcome Anthony Feliciano to testify. You may begin when you are ready.

SERGEANT-AT-ARMS: Time starts now.

ANTHONY FELICIANO: Good afternoon. Thank you, Chair Rivera and committee staffers. I am Anthony Feliciano. I am the director of the Commission on Public Health System. It is often said that what gets measured gets done, but the opposite is also true. What also gets preferable value for measuring to assess effective response can be [inaudible 01:59:03] inequities. And I've said this many times in many other committee hearings and in part of my testimony, it talks a lot about what Elizabeth addressed, so I'm not going to go through that, but they are critically important. What I want to go into is we know that the city has limitations on their role of jurisdiction over hospitals. Obviously, that is the primary responsibility of the state. However, I think that the following things that the city can address to a strength in some three fundamental elements of the pandemic which is preparedness, prevention, detention, and response.

Actually four. And I want to address some clear parts of this. I think we need to develop a comprehensive public health plan around COVID responses that were addressed problems of cultural competency, equity, and institutional oversight. This really includes preparedness around capacity assessments and paired them with strategies to promote readiness and implementation. The objective was really to generate some community mitigation guidelines and pandemic response triggers so that local policymakers and community-based organizations and leaders have a roadmap for early targeted and coordinating implementation of surveillance, medical and prevention, holistic and mutual aid approaches, and measures to reinforce medical and public health capacities. I also believe that we need to start enforcing pandemic ready standards for hospitals and health systems in ensure that these institutions respect and promote health equity. I also believe we have to make standard practice to collect and share data on the risk of specific communities. Most notably, black communities, Latin X communities, and other marginalized communities. People with disabilities, Native Americans, elderly, and this

could [inaudible 02:00:54]. I think we have to craft these strategies and programs and budgets and plans for targeted public health investments to increase the resilience of marginalized communities. Efforts cost money and relative to economic and health risks, we need to adopt an equity assessment with the city budget on what is provided to support hospitals and hopefully expand out to every part of the city budget process. And part of that, to me, leads to we need to have racially equitable policies and budget decisions should be defined as a resilient, and equitable outcome by race, regardless of any indication of racial bias, integrated explicit consideration of racial equity and to every consideration of New York State and New York City government budgets. I think also we need to ensure that the Board of Health declares racism--

SERGEANT-AT-ARMS: Time.

ANTHONY FELICIANO: as a public health crisis. The last time the Board of Health met was in September and they should pick up the ball again on that referendum. I think we have to visually exercise the jurisdictions of the Commissioner, the New York State Department of Health for controlling

the COVID pandemic along with New York [inaudible 2:02:07]. We seek some partisan leadership around that and seek a broader thinking about that. Pending the governor signing Rivera as Bill and the Godfrey bill to determine that contact tracing date is not shared, we think this city should prepare for its own legislation around that. I think we need to develop some resources around health impact assessment tools similar to California, but a little bit much broader looking at [inaudible 02:02:32] and other hospital metrics. I think we need to create some COVID clinics like creation of the workplace [inaudible 2:02:39] and expanded the idea of sense of excellence model that Health and Hospitals looking into COVID clinics. Those who survived COVID are still susceptible and have differential health outcomes and treatments. They are showing cardiac, renal, and respiratory complication events after no longer having COVID and they shouldn't-- they should have ability to research and development of common practices and standards of care. Also, I want to ensure that PPE applications required training and annual updates similar to what we're doing with Ebola. Just one part that I think the city needs to

be really vocal at protecting New York City hospitals and other state facilities to the state. We have to shift test in tracing back to New York City Department of Health. New York Health and Hospitals is already financially burdened and added pressure and responsibility without any access to more funding, it's going to create more of a burden. We have to shift away from [inaudible 02:03:34] for COVID-19 test and trace, informatics, and operations. And I think we still need to go back to resource and shifting the resources on the police department to the more public health and investments in our public health and social network. It truly was not done, instead it was a shell game by the mayor and we have to do equity around charity-- like Elizabeth mentioned around indigent care pool, those formulas need to be changed and more just enrich the safety net. I think we need to call for a moratorium on hospital closures and service reductions as a city to the state. Passage of a new health act with I know is a long road ahead. But I think developing purchasing pools based on local need and not institutional interest and competition is critically important. Maybe looking into diagnostic

specifically COVID-19, a Medicare that's [inaudible 02:04:28. Need for minimum safety standards and ratios that the state has not done properly and definitely coordinate proper distribution of PPE to staff. So I think this needs some real holistic and broad approach and, while the city may not have full powers over the hospital, there's plenty of advocacy and creative thinking that should be done. Thank you.

COMMITTEE COUNSEL: Thank you for your testimony. We will now hear from Judith Cutchin. You may begin your testimony.

SERGEANT-AT-ARMS: Time starts now.

JUDITH CUTCHIN: Hi. Thank you, Chair Rivera, and committee for allowing me to testify today. My name is Judith Cutchin and I am a Health and Hospital nurse at Woodhall and I'm the president of the New York City Mayoral Executive Council representing 9000 registered nurses. The COVID 19 emergency severely affected hospitals throughout the state will New York City hospitals was especially hit hard. In New York City, during the height of the surge, in March and April, daily hospitalizations averaged more than 12,000 including more than 3000

ICU level patients. Based on experience of NYSNA nurses, we believe that there are some weaknesses in our hospitals that need to be addressed if we are to be ready for the next COVID 19 surge. First, it is clear that staffing was a big problem both at H&H and in the private sector hospitals. At H&H and many of the safety net private hospitals, nurse staffing has chronically been worse than it has in the large hospital networks. During the COVID surge in March and April, the situation got much worse. In the ICUs, there was supposed to be no more than two patients for each nurse, but we saw nurses getting four or six and as many as eight patients at a time. This is unacceptable and it impacted the health and safety of the nurses and the patients. We also noted that the staffing was unequaled between hospitals and some hospital nurses had a patient assignment of one to four or one to five while others had seven-- one to seven or one to eight for the same level of care. We need to implement uniform standards so that every patient gets equal levels of quality care. This is especially important to address racial and economic inequality that affects outcomes. We saw that the impact of COVID was much worse for black and Latino

patients who had higher mortality and hospitalization rates. Any quality in the level of staffing and hospital care has lethal consequences. As the second search 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. Second, we need to put in place consistent infection control and PPE policies to protect nurses and patients. During the surge, there were different standards and policies coming from the CDC, the state, and city DOH and hospital management. It is important that we have uniform standards of infection control and PPE to make sure that nurses and other staff are safe and that the patients get the care that they need. This means that we need to have infection control based on the science and clinical standards and not based on the need to ration PPE. In addition, nurses and other direct care providers must be involved in the design and implementation of --

SERGEANT-AT-ARMS: Time.

JUDITH CUTCHINS: policies and protocols. Third, we have to address the racial and social inequalities in our hospitals. Black and Latino

communities have suffered worse health outcomes and have less access to care for a long, long time. COVID made that situation even worse. The racial inequalities in our economic and healthcare system must be fully recognized and the city must take steps to address these factors before the next COVID surge. Fourth, we have to take steps to prevent hospitals from closing services or units on the basis of profit motives. There is a trend of private sector hospitals closing unprofitable units to replace them with surgical and specialty service that make more money. Psychiatric beds have been a particular problem at New York Presbyterian. All the hospitals have been closing psych beds for entire units. During COVID, they were able to speed this process up by using the emergency to convert these units to COVID beds. Those psych beds need to be kept open because there is definitely a need for them. The city of New York must take action to protect these vital services before the next COVID surge and leads to yet more closures. Finally, we believe that steps must be taken to provide support to H&H and the private sector of safety net hospitals. These hospitals are already under financial pressure and

COVID has made it worse. The city has to maintain the support of H&H and look to expand support from private safety nets. We cannot allow the budget crisis to result in closures or reductions of services provided by safety net hospitals. COVID has not gone away and if we ought to be fully prepared, we need to address the acute problems in our hospital system. Thanks again for allowing me to testify today.

COMMITTEE COUNSEL: Thank you all for your testimony. I am now going to turn it over to Chair Rivera for questioning.

CHAIRPERSON RIVERA: Thank you so much. I do have a few questions for the panel. I guess specific ones for each of you, but of course feel free to chime in. I guess I'll start with Ms. Benjamin. What recent changes, if any, have happened on the state level to charity care funding and was it enough?

ELIZABETH BENJAMIN: Well, yes. We actually did win a major victory in March which is they used to allocate the 1.2 billion dollars indigent care pool based on an old formula that allowed the hospitals to draw down indigent care pool

funding for their bad debt. Bad debt could be for rich people or poor people instead of allocating it hundred percent on the volume of services provided to the uninsured and Medicaid patients. So, we finally closed-- it was about a 15 percent loophole. That one has finally been closed. Nonetheless, I would submit we still don't go far enough. Every other state in the country only allocates their version of the indigent care pool funding which is funded by a federal stream of money called the Disproportionate Chair Hospital Funds. Every other state, including California where Dr. Katz came from-- in fact, you said he was flabbergasted we don't do it that way. Every other state just targets that funding to true safety net hospitals. In New York, we are an anomaly. We pass it out and we spread it around like peanut butter. Every hospital gets this funding whether they have served poor people are not. Whether they offer financial assistance or not. Whether they sue their patients are not. So that's wrong. We should actually-- you know, we don't have so much money in our healthcare system to be wasting precious indigent care pool funding is on the likes of, you know, very rich hospitals like New York

Presbyterian. I mean, they really don't need it. Why are we spending 60 million dollars a year of these precious funds them when we could sure up hospitals that are going to be closed or, as nurse Cutchins said, don't even have enough PPE or staffing to serve needy patients. That's what we need to-- the reckoning time is now and the indigent care pool funding really should be rethought. Hospital rate setting should be rethought. Global budgeting like Maryland is another great option we should be exploring. Obviously, adopting a single-payer health care proposal is another, you know, way we could-- you know, avenue we could go which would be great in terms of allocating our resources more clearly. But this system of incredible inequity has to stop.

CHAIRPERSON RIVERA: Thank you so much. I agree with you wholeheartedly. I touched on my opening remarks on just the very, very problematic formula for how we distribute these dollars to our healthcare system. And I would hope that the pandemic was just one more reminder, an urgent, tragic reminder, of how this is hurting our poorest New Yorkers in our communities of color and--

ELIZABETH BENJAMIN: And I think-- Oh. I'm sorry. Just one other thing. I think this year, because the very rich hospitals benefited so wildly from the Cares Act funding compared to the safety net hospitals, maybe this is the year to say, okay. We are not going to pass out indigent care pool on even the Medicaid and uninsured formula because the rich hospitals to do a volume of Medicaid services. Maybe we should only be spending the indigent care pool money on the hospitals that are about to go under, first of all, but also that serve needy communities. You know, high need communities. Communities of color. You know, I think we could-- this is the moment where we might need to be a little more creative since there really has been some major winners and losers with the Cares Act funding.

ANTHONY FELICIANO: We all worked really hard, as advocates, to just get the enhanced safety net legislation to in order to meet some part of the formula, but there is still so much distortion. And you have to be clear, safety net hospitals-- black and brown communities rely on safety net facilities. If you don't give them equally, it is a racist act in the same way because

of the budget distribution of that. And there should be a tiered approach. I think, particularly, for hospitals who have-- some may have offshore accounts and have money in other places and that should be all addressed in [inaudible 02:14:49] and any distribution of funding that goes into the system.

CHAIRPERSON RIVERA: Thank you. I agree with that. I wanted to ask-- I asked this question to Greater New York and I wanted to ask you specifically, Ms. Cutchin, if that's okay. What I said earlier in the line of questioning is that at the peak of the pandemic, we know it was all hands on deck. Understood. And you will, representing the nurses-- you know, we have a long, long fight on safe staffing, on making sure that you had the resources you need even pre-pandemic, but during COVID-19 when it was, indeed, an all hands on deck situation. People who had been retired or otherwise had not been trained in related medicine were called to help because we were so short staffed. Who was responsible-- and I just want to underline some that redeployment of inexperienced staff was sent to inpatient and ICUs. And so I want to ask, you know, how was that process for you, your members, your

colleagues? Who was responsible for ensuring that new staff received necessary critical training? Did the agencies or Greater New York or some of these institutions assist you with this or was it up to the individualized hospitals to provide this training amidst everything else going on?

JUDITH CUTCHINS: I believe it was up to the individual hospitals. Most of the training was based on the education department recommendations. The training was swift and, in a lot of cases, you know, the members were very worried about patient care. They were worried that it was going to harm a patient because they weren't adequately trained. I do applaud H&H for all the efforts, but, however, we are going into a next surge and we have to ensure that people are properly trained and not having elbow to elbow training, not having last-minute training they say, okay. Or one day trainers. Lives are at stake as it was said over and over again. These are black and brown patients and vulnerable communities, underserved communities, and we want to ensure that the quality. That everybody gets the same appropriate care. So education has to be on the front. Training has to be first. Training has to be

real strict on caring for COVID patients to prevent the spread of COVID which is our goal.

CHAIRPERSON RIVERA: Thank you very, very much. You know, I agree that, clearly, lessons learned. We tried our best considering all the circumstances, but the inequity was there. I think just as Ms. Benjamin and some of those statistics that you gave, 6.4 beds per 1000 people in Manhattan, versus 1.5 per thousand people in Queens. You don't necessarily have to be a policy expert to realize how very, very troubling that is. So, I don't know if there was anything else that the panel wanted to add. You know, I looked to you all repeatedly when I am doing this work, your guidance, your advice, your expertise has been absolutely invaluable to kind of my journey on this hospitals committee trying to support her Health and Hospitals system and all hospitals citywide. If there was anything you wanted to add before I adjourn this hearing, I do welcome any comments or anything else.

ANTHONY FELICIANO: I just want to add-- and I didn't mention it before. Ut's been always an uphill battle to every Medicaid waiver and the latest one [inaudible 02:18:40] and there's no

consistent standard way of looking at community engagement outreach in a more equitable way. It seems to be very sporadic, episodic, and response [inaudible 02:18:58] and so this happened the same with COVID. I commend Health and Hospitals for contracting for navigators and community engagement, but they can broaden that expansion. I think the other part is that we have to really serious and clear to each other that there are political influences and issues that play out in justifying inequities and [inaudible 02:19:19] around it out of either fear that we don't want to have a safe space for each other or not being brave enough. Either one is still problematic for black and indigenous people of color and immigrant communities.

CHAIRPERSON RIVERA: Agreed. I know we have a long way to go and we've been talking about equity and access to healthcare for a long time for our neighbors with disabilities just to starkly marginalize. I know we have a long way to go and we still are in this pandemic. So I want to thank you all for-- Christopher, did you want to add something?

CHRISTOPHER SCHUYLER: Thank you. I just wanted to kind of add my voice to the choir of what Anthony was just saying, too. Just to kind of really-- you know, not exactly sure how to better encourage kind of hospitals to initiate conversations with stakeholders, but we are here. We are in [inaudible 02:20:34] but here. We have the energy and we're always looking to kind of, you know, help influence and educate on policy decisions and, you know, I mentioned at the beginning of my testimony that NYPLI is a member of a coalition of advocates who are fighting for medical access for people with disabilities and Dr. Katz is been kind of instrumental, you know, and kind of partnering up with us, but, you know, the hospitals around the city-- it seems like we only really engage in a dialogue if we are planning to file a lawsuit and, you know, it would be kind of much nicer if it were more proactive rather than reactive all the time. That's it. Thank you.

CHAIRPERSON RIVERA: I appreciate that. Thank you. I did let the administration Greater New York Hospital Association know that they are would be honest, candid feedback in this hearing and I expect

that every time. That's why I convene these and I do hope that we can all come together in some way to talk about what's next and how we can be collaborative. And as proactive as possible considering all of the circumstances. I think we want to do one last call for anyone else who wanted to testify, but I wanted to thank you all. I wanted to thank the essential workers, the frontline staff, added to the New York Nurses Association. Thank you for testifying. Thank you for following up with me. For always being there and for rallying for-- taking care the staff, but also the patient's, as well. That's what we want to do is make sure that people feel like, in a city as wealthy as New York, that the people have access to the best care regardless of where you live or who you love or where you came from. So I want to thank this amazing panel who was quite brilliant and see if there is anyone else who would like to testify.

COMMITTEE COUNSEL: Thank you, Chair. At this point, if we can ask if we inadvertently missed anyone that is registered to testify today and is yet to be called to please use the zoom raise hand function now and you will be called on in the order

that your hand has been raised. Okay. I'm not seen any in spirit I will turn it back to Chair Rivera to adjourn the meeting.

CHAIRPERSON RIVERA: Thank you all, again. I think we all share the fundamental belief that healthcare is a human right and I'm looking forward to working with you to make sure that we can deliver that for every New Yorker. And, with that, this hearing is adjourned. Thank you to all the Council staff continues to make this happen.

[gavel]

C E R T I F I C A T E

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

Date November 15, 2020