BEFORE THE NEW YORK STATE LEGISLATURE:
SENATE STANDING COMMITTEE ON HEALTH;
SENATE STANDING COMMITTEE ON INVESTIGATIONS & GOVERNMENT OPERATIONS;
ASSEMBLY STANDING COMMITTEE ON HEALTH;
ASSEMBLY STANDING COMMITTEE ON OVERSIGHT, ANALYSIS & INVESTIGATION; and
ADMINISTRATIVE REGULATIONS REVIEW COMMISSION

VIRTUAL JOINT PUBLIC HEARING:

COVID-19 AND HOSPITALS

Date: August 12, 2020
Time: 10:00 a.m.

PRESIDING:

SENATOR GUSTAVO RIVERA
Chair, Senate Standing Committee on Health

SENATOR JAMES SKOUFIS
Chair, Senate Standing Committee on Investigations & Government Operations

SENATOR SIMCHA FELDER
Chair, Administrative Regulations Review Commission

ASSEMBLYMEMBER RICHARD N. GOTTFRIED
Chair, Assembly Standing Committee on Health

ASSEMBLYMEMBER JOHN T. MCDONALD III
Chair, Assembly Standing Committee on Oversight, Analysis & Investigation

ASSEMBLYMEMBER DAN QUART
Chair, Administrative Regulations Review Commission

SENATE MEMBERS PRESENT:

Senator George Borrello

Senator Pat Gallivan

Senator Pamela Helming

Senator Brad Hoylman

Senator Andrew J. Lanza

Senator Betty Little

Senator Monica Martinez

Senator Jen Metzger

Senator Thomas F. O'Mara

Senator Patty Ritchie

Senator James Tedisco

ASSEMBLYMEMBERS PRESENT:

Assemblymember Tom Abinanti

Assemblymember Jake Ashby

Assemblymember Charles Barron

Assemblymember Edward Braunstein

Assemblymember Marianne Buttenschon

Assemblymember Kevin Byrne

Assemblymember Kevin Cahill

Assemblymember Steve Cymbrowitz

Assemblymember Nathalia Fernandez

Assemblymember Andrew Garbarino

Assemblymember Aileen Gunther

ASSEMBLYMEMBERS PRESENT (continued):

Assemblymember Ellen Jaffee

Assemblymember Ron Kim

Assemblymember Brian Manktelow

Assemblymember Missy Miller

Assemblymember Steven Otis

Assemblymember Linda Rosenthal

Assemblymember John Salka

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SENATOR RIVERA: Good morning everyone.

Welcome to the third -- well, it is a first of such hearings, but the third that we are doing on the impact of COVID-19 on different sectors of the health infrastructure of the state of New York.

Today we will be focusing on the impact on hospitals.

Just would want to get a couple of very quick procedural things out of the way, and we will get right into the testimony.

We are joined today by my co-chairs in the Senate Majority: Senator James Skoufis, chair of Investigations, as well as chair of Administrative Regulations Review, Senator Simcha Felder.

Also joined from the Majority by Senator Brad Hoylman, Senator Jen Metzger, and Senator Monica Martinez.

We're also joined from the Minority, we have Senator Pat Gallivan, the ranker on the health committee; ranker in -- and then we also have Senator Patty Ritchie, Senator Jim Tedisco, Senator Pam Helming, Senator George Borrello, Senator Betty Little, Senator Lanza.

And with that, I will pass it off to my Assembly colleague for some procedural matters, and

we will get right into the questioning.

ASSEMBLYMEMBER GOTTFRIED: Okay. You know, before I do the procedural things, could our Co-Chair John McDonald introduce the assemblymembers who are in the hearing?

SENATOR RIVERA: And as he is still on mute, I just saw that Senator Tom O'Mara, the ranking member of the Investigations Committee has joined us.

Apologies that I missed you, sir.

Go ahead, Assemblymember.

ASSEMBLYMEMBER MCDONALD: In order of how they appear:

Aileen Gunther, Charles Barron, Edward Braunstein, Ellen Jaffee, Jake Ashby, John Salka, Kevin Cahill, Missy Miller, Ron Kim, Steve Cymbrowitz, Tom Abinanti.

Obviously, Dan Quart is with us as well. I'm sure he'll be speaking.

I see Ranker Brian Manktelow. Kevin Byrne.

And I believe that's it for now, but I know more members will be joining us.

ASSEMBLYMEMBER GOTTFRIED: Did you read off Ellen Jaffee?

ASSEMBLYMEMBER MCDONALD: I did read off

Ellen Jaffee.

ASSEMBLYMEMBER GOTTFRIED: Oh, okay.

Okay. Well, thank you.

I will just do some quick procedural points.

You know, this is going to be a long hearing, and, so, every three hours or so we will take a 10-minute break for what the health committee calls "ambulation and toileting."

And a safety reminder: Nobody should talk while -- in the hearing while they are driving.

We will not be having opening remarks for this hearing, in the interest of time.

Witness testimony will be limited to 5 minutes each.

Question-and-answer time will be limited to 5 minutes, per panel, for committee chairs and ranking minority members, and -- committee chairs and ranking members of the sponsoring committees, and 3 minutes each for other committee members.

You know, we've had two days, about 21 hours, of hearings on COVID-19 and nursing homes, adult homes, and home care.

So, at this hearing, testimony and questions will be limited to the topic of COVID-19 and hospitals.

Committee -- excuse me.

Committee members may submit written questions, whether on the long-term-care topic from our previous hearings, or COVID and hospitals today, may submit written questions to us, which we will forward to the appropriate witness, asking that the witness respond in writing within three weeks.

And last point is, that each of our witnesses, I will ask them to swear or affirm that the testimony that he or she is about to give is true.

And that's it at my end.

SENATOR RIVERA: Thank you, Assemblymember.

A slight correction, however.

We have not done hearings for 21 hours.

We have done hearings for about 23 hours.

So, just thought I would make that small correction.

Moving to our first panel, we are joined by Commissioner Howard Zucker of the New York State Department of Health.

He is accompanied by Jim Malatras, president of the Empire State College, and, Gareth Rhodes, deputy superintendent and special counsel for the Department of Financial Services.

ASSEMBLYMEMBER GOTTFRIED: And do each of you swear or affirm that the testimony you are about to give is true?

COMM. HOWARD ZUCKER: I affirm.

GARETH RHODES: I affirm.

JAMES MALATRAS: I affirm.

ASSEMBLYMEMBER GOTTFRIED: Okay. Fire away.

COMM. HOWARD ZUCKER: Good morning, members of the New York State Senate Committee on Health, Investigations & Government Operations, and Administrative Regulations Review Commission, and Assembly Committee on Health; Oversight, Analysis, and Investigation; and Administrative Regulations Review Commission.

Thank you for the opportunity to speak before you today.

This morning I want to talk about the central role our hospitals played in this unprecedented emergency.

As a physician and as an intensivist, I spent decades working in these facilities, including two of the New York City hospitals.

Intensivists care for critically-ill patients, and in my case it was children. In that position, that clock, that clock on the wall, is

working against you; it never stops for you to get your bearings or to try something again.

That's exactly what happened on the scale that was previously unimaginable when COVID-19 besieged New York hospitals.

From the arrival of the first laboratory-confirmed cases in New York State on March 1st, the number of cases rose exponentially, with the number of cases doubling overnight on March -- on both March 5th and on March 6th.

New York hospitals had long been preparing for this.

Since 2009, New York State Department of Health has regularly staged practice drills for H1N1 pandemic, influenzas.

We now know that our scenarios and our exercises could not fully anticipate the symptoms and bodily damage inflicted by COVID-19 or a transmission pathway as devious as this disease.

Those drills also could not have fully anticipated the enormity of the strain on our health-care system and our public health systems that a pandemic of this scope, swift onset, unique nature, and infectiousness could bring; nor did we predict in those drills that states would be

responding to such devastation without any coordinated system of federal support, intervention, and detection.

The first challenge we recognized as New York's COVID-19 surge began, was that our 53,000 statewide licensed bed capacity needed to be drastically and dramatically increased to meet a demand that some statistical models had placed as high as 140,000 beds.

These existing 53,000 licensed beds were disbursed across a vast health-care system, consisting of 23 public and 200 private hospitals, each with their own operations, policies, and systems.

On March 23rd, we issued a directive, requiring each hospital to double its licensed bed capacity.

New York hospitals rose to that challenge.

We directed hospitals statewide to cancel all elective surgeries in order to make available as many hospital beds as possible to treat COVID-19 patients.

Initially, models predicted significantly larger inpatient facility needs.

The initial estimates were, that

New York State would need 140,000 hospital beds by the end of April.

We worked with the Army Corps of Engineers, the Department of Defense, and the National Guard to erect and staff alternate care facilities, like the Javits and "The Comfort."

1,095 patients were treated at the Javits during the duration of its operations.

"The Comfort," where 182 patients were treated, was operated by the U.S. Navy Medical Corps, and they established the patient admissions' criteria.

Javits and "The USNS Comfort" were originally limited to non-COVID-19 patients, based on a decision by the federal entities that were staffing these alternative care sites.

But by April 3rd, in the case of Javits, and on April 6th, on the Comfort, we had successfully pushed to get them to accept COVID-19 patients.

That was adapting to the needs of the hospitals increasingly stressed by the rapidly growing COVID-19 patient census.

In addition, the State aggressively worked to establish other alternative patient-care sites in estimated high-impact areas, including The Brooklyn

Center at -- with 280 beds; the South Beach Psychiatric Center in Staten Island, which is managed by Northwell, with 260 beds; and additional sites constructed, but never activated, included SUNY Stony Brook, 1,028 beds; SUNY Old Westbury, 1,024 beds; and the Westchester Convention Center with 110 beds.

Building this capacity was an extraordinary effort, and we were ready to treat thousands of additional COVID-19 patients if it became necessary.

Bending the curve was an even more remarkable effort by New Yorkers that alleviated the need to open these sites.

We began ordering PPE, ventilators, and other supplies to be sure we could restock our hospitals if the supply chain failed them.

We set up staffing portals, and asked for health-care workers to sign up to help in the battle against COVID-19.

And when the supply of those medications that were needed to care for the most critically-ill COVID-19 patients in ICUs ran low due to extreme demand and supply-chain issues, the State identified those hospitals with the most urgent needs, and worked with the pharmaceutical wholesalers to ensure

that New York hospitals were prioritized, which resulted in larger and more frequent distribution of these medications into the state.

The governor issued executive orders to expand scope of practice and limit restrictions so that more health-care providers could provide care to more people as the hospital emergency departments and inpatient beds quickly filled.

However, these numbers and policy decisions cannot effectively characterize the experience of physicians and other health-care professionals living through COVID-19 inside these hospitals.

At every hospital, in every ward, on every floor, in every hallway, and on every gurney, health-care workers were making critical decisions --

SENATOR RIVERA: Commissioner?

COMM. HOWARD ZUCKER: -- focused solely --

SENATOR RIVERA: Commissioner, how much longer do you have, sir?

COMM. HOWARD ZUCKER: Four pages. Three, four minutes.

SENATOR RIVERA: Which is, definitely, you're not going to be able do it all.

COMM. HOWARD ZUCKER: All right.

SENATOR RIVERA: If you could actually try to conclude in the next 30 seconds, I'm giving you some leniency with an extra minute.

COMM. HOWARD ZUCKER: All right, well, I will tell you that -- well, let me finish this paragraph.

Perhaps 20 minutes after the first patient was sick, they had to make another decision, and another decision after that.

In the meantime, some hospitals that were nearby, but were -- had no way to access it.

For instance, in the third week of March, Elmhurst Hospital was inundated with patients at a time when other hospitals had capacity, but there was no system in place to immediately share the load.

And we needed to create a way to make this overtaxed system work efficiently, to save lives, to improve patient outcomes, and to alleviate the stress on front-line workers.

And in many other --

SENATOR RIVERA: Okay.

There's, obviously, the rest of your -- if the rest of your testimony is the written testimony, it is all -- will be on the record.

So we'll now move to questions.

Thank you for your testimony.

We'll lead off by the Senate, by Senator James Skoufis.

SENATOR SKOUFIS: Thanks very much.

Good morning, everyone.

Thanks for your testimony, Commissioner.

And I do want to express my gratitude to each of you, and the governor, and your team, for your remarkable work over the past five months.

You know, there's a lot of Monday-morning quarterbacking that happens, but I think very few people have the full appreciation for just how quickly things were changing, just how difficult things were in hospitals and elsewhere.

And I do want to acknowledge that before I get to my questions.

First, can you talk to me, I know it's coming out in a couple of days, but, we talked, on page 128 of last year's budget bill, S1507-C, it's speaking to a study that all of you were directed to -- to engage with, looking at staffing in hospitals and nursing homes and elsewhere.

It reads: That the department shall report its findings and the recommendations to the

commissioner of the department of health [indiscernible] present of the Senate and speaker of the Assembly no later than December 31, 2019.

I appreciate that this study is being released, I guess, in two days, but, make no mistake, the department ignored the law.

And I think that's kindly putting it.

You could argue that the department is breaking the law, in not issuing this report by December of last year, which, no doubt, could have informed us a bit more, leading into this pandemic.

Can you speak to, why, on August 14th, we will be getting this report, and why we did not get it on December 31st?

COMM. HOWARD ZUCKER: The report needed to be reviewed further.

Obviously, in January, when this pandemic started, or, in February, I should say, when it really took off, and there were issues, we were redirected to those issues.

The report is -- I've glanced at that report -- well, I've read through the report, but I wanted to look at that one more time. It's going to come on August 14th, which is on Friday.

And I believe that the efforts of the

department to address the needs of the hospitals were met, whether it's an issue of staffing or other needs that they had.

But let's -- I'm happy to discuss the report after it comes out.

SENATOR SKOUFIS: Okay, well, I -- [indiscernible] and I noted this last night in a separate hearing: You know, this is a pretty longstanding practice, when these types of deadlines, via legislative directive, are often ignored by agencies.

Quite frankly, we could have taken you to court and compelled you all to release this far sooner than August 14th.

That's on us, and we ought to be doing more of that as a legal prerogative.

But I really do hope that your department, and all the agencies, do a better job of not ignoring the legislature when we ask you -- not ask you, direct you to do something in statute.

If I could move on:

So PPE, no doubt, was an enormous challenge that extended far beyond our state's boundaries, and was, predominantly, a challenge that resulted from the federal government not doing its job, one of

many instances over these past five months.

I know that [indiscernible] the governor just announced a consortium, with seven other states, moving forward in sort of a purchasing agreement, if you will.

But what else can we do?

Knowing the federal government was just so unprepared, making sure we had masks and gowns and gloves for our hospital workers, what else can we do?

Are we doing more to try and encourage manufacturing of this kind of equipment in the state?

What more can we do?

COMM. HOWARD ZUCKER: So, number one, the governor has announced that there needs to be a 90-day supply of PPE available to the hospitals.

So we are addressing that.

We are also looking across the state, and elsewhere, about, what one can do regarding manufacturing more PPE, and making sure that we have access, and we don't end up in a situation where we have to call and compete against our fellow states to get the equipment.

This was one of those situations where we

recognize the challenges that we face by not having the ability to --

SENATOR SKOUFIS: I appreciate that. Thank you.

And I just want to get in my last question. And perhaps, Mr. Malatras, and thank you for being here -- Dr. Malatras, sorry:

Are there any regrets that you have, looking back?

Again, hindsight is 20/20.

Something you would do differently in hospitals, knowing what you now know over the past five months?

DR. JAMES MALATRAS: I think we're still actively in the response at some level. It's not the same, but we're preparing.

Thankfully, in New York, our infection rate among one of the lowest in the nation. Our hospitalizations are down.

But we are preparing, actually, for the fall.

And, also, as you see what the other states are doing, we have about 40 or so states that are actually increasing exponentially across the county, [indiscernible] New York which is actively still managing the cluster crisis that is still here.

So, we're still in active response.

We'll have time for retrospective [indiscernible].

SENATOR SKOUFIS: Okay.

Thank you.

SENATOR RIVERA: Thank you, Senator.

Thank you, Mr. Malatras.

Assembly.

ASSEMBLYMEMBER MCDONALD: We will now go to our health chair, Mr. Richard Gottfried.

ASSEMBLYMEMBER GOTTFRIED: Thank you.

Commissioner, I'd like to -- since our goal here is learning for the future, long before you became commissioner, but only a couple years before I became health chair, New York started on a path of dramatic reductions in hospital capacity.

At the same time, we have seen increasing consolidations within -- within the hospital industry. I think it's probably almost every hospital is now part of some network headed by a large academic medical center. A lot of the reduction in capacity [inaudible] community hospitals.

So my question is: Has -- have those trends, reduction --

SENATOR RIVERA: Assemblymember, if I may interrupt for one second, I want to make sure that the time is rolling.

It is not rolling yet.

There you go.

I'm sorry.

Continue, Assemblymember.

ASSEMBLYMEMBER GOTTFRIED: Okay.

-- so have those reductions in capacity, and particularly reductions in capacity of community hospitals, and consolidation of hospital systems, have we gone too far with those trends?

Do we need a course correction?

And is that one of -- have we learned that from this epidemic?

COMM. HOWARD ZUCKER: I think the discussion here is obviously about the pandemic, and the hospitals are part of it.

I think what we have learned from the pandemic, and are learning from the pandemic, as we know, this is far from over, is that we have to look at all parts of the hospital system, and figure out how to make sure the needs of the patients are met.

I think this is a longer discussion about health-care delivery, which I'd like to have with

you, regarding hospital inpatient needs, outpatient needs, and where we're going, and would be happy to discuss that.

But with regards to the pandemic, there are many lessons we've learned regarding hospital delivery, both inpatient and outpatient and hospital services.

DR. JAMES MALATRAS: And, Chairman Gottfried, if I may, because it builds on Chairman Skoufis's question as well, I think part of it is, you need different amounts of beds, or number of capacity, at different times.

And what we learned with the current pandemic is, you don't always need the same amount of beds at normalcy, but you may need to ramp up exponentially, given a crisis like we witnessed.

So what the "Surge & Flex" regulation that the department of health just put out, requires hospitals to be ready to increase their capacity by at least 50 percent.

While you also need beds, you need staffing, which is why we did the staffing portal, which brought about 100,000 people into the system, as needed.

And then the equipment to go along with it.

As we all know, ventilators, and other key PPE, were key to this success.

So building that capacity also all works together.

So I think there's a level of preparedness, that we really focus on preparedness for future response, to have the flexibility to quickly adapt and grow, as needed, as well as, in addition to your long term, do you have enough beds, generally?

I think the health-emergency thing also had to be addressed, which we did do the "Surge & Flex" regulation.

ASSEMBLYMEMBER GOTTFRIED: Thank you.

SENATOR RIVERA: Thank you, Assemblymember.

We'll follow up with Senator Felder, recognized for 5 minutes.

SENATOR FELDER: Yeah, good morning.

I want to echo my colleague Senator Skoufis's thanks and compliments for all the work that you've done.

And I -- I -- I wanted to address the issue of -- of having somebody, a family member or somebody close to the patients, in the hospitals during this time.

My own experience has been, over the years:

Thank God, I have a mother who is very elderly. And I can't remember any time that she's been hospitalized, and she has frequent miles in the emergency room, unfortunately, that, unless somebody was with her, I -- I -- I can't forecast, you know, and say she'd be dead, God forbid, but, I think so, because the nature of the emergency rooms are, that they do their best. Things are just happening.

So during this time, I understand that a pandemic is not a usual thing, obviously.

But, you know, when a loved one is hospitalized, the family and friends, usually, at least somebody stays at their bedside some portion of the time, to make sure they get comfort, care, and assistance that's really vital to the recovery, besides, obviously, the medication.

It's clear that, this time, all the way till -- I mean, I don't know, you know, exactly when it stopped, but the guidance and the rules that the hospitals implemented was not to allow anybody to stay with their loved ones at any point of time.

And it really was intolerable that patients languished alone, scared, and unable to communicate; they couldn't communicate through their final days, and family members had no way of knowing what was

going on until it was too late.

And I'm certain that we can do better.

And I'm just wondering whether you have, you know, for the future, I'm not talking about the past, I'm talking about for the future, is there some plan to improve this policy, whether -- you know, whether they have the abilities on iPads, or even -- I don't have the answer. I'm sorry.

You know, usually, I don't like posing a problem without an answer, but, I don't have a good answer.

But I do know that, you know, I'm using my mother again, that anytime she goes into the emergency room, if there's no one there, she's not coming out.

That's the story.

So, is there some commitment to being able to have a family member?

I mean, the nurses, you know, they dressed up entirely, you know, to make sure that there was no -- no contagion, or whatever else.

I can't -- I -- I -- I know I'm speaking to the converted when I say that a family member is a critical part of taking care of the patients.

And it was -- it was horrible.

I can't say anything else.

I'm just asking for your help, and commitment, to trying to do something, some way, for future, God forbid, if something happens, so that family members or close ones can be there.

They don't have to be there all day, but, at some point during the day, so that they're there, you know, really, at the worst times in a person's life.

COMM. HOWARD ZUCKER: So I hear you on this.

Having been a patient, having been a relative of a patient, and as a doctor, I can tell you I really understand that situation.

But you have to remember where we were at that moment in time, and we were trying to make sure that this situation would not spread through a hospital. We wanted to be sure that we protected the patients.

We did have a visitation policy that was put into place in May -- at the end of May to address these concerns.

I absolutely understand where you're coming from, and it is very tough for patients, but, we are at a different point in time.

We have more supplies. We understand the

disease better. We have the "Surge & Flex" issues.

There are so many things we have done.

But back then, when it began, the goal was to make sure that this was not going to spread throughout the hospital where there are many vulnerable patients, for all -- for many reasons.

So I hear you.

SENATOR FELDER: Thank you.

Thank you, Senator.

Assembly.

ASSEMBLYMEMBER MCDONALD: Thank you.

Our next speaker will be Assemblymember Dan Quart.

ASSEMBLYMEMBER QUART: Good morning. Thank you very much.

And thank you, Dr. Zucker, for your statement and your testimony.

I am chair of the Assembly's Oversight Committee on Regulations, so I'll start with my questions in the area of regulations.

The department of health recently adopted emergency regulations that require hospitals to maintain a 90-day supply of PPE; 60-day supply, nursing home.

I think Senator Skoufis mentioned that a

little in his questions.

However, this requirement is based on a so-called "burn rate" taken specifically from April 19th through April 27th.

And the CDC's, quote/unquote, contingency and crisis guidelines that allowed treating two or three or more patients without changing PPE.

On March 28th, Governor Cuomo stated that New York State was concerned that these guidelines were inadequate, and that, quote, Dr. Zucker is looking at that. If we believe the CDC guidelines do not protect health-care professionals, we will put our own guidelines in place, quote/unquote, by the governor.

A few days after that, DOH issued guidance, with contingency and crisis recommendation, based on CDC guidelines.

My question is:

Did department of health, did New York State, review the CDC policies, and determine that they were insufficient?

And, if there was some review, was that ever made public; was the documentation of that review made public?

COMM. HOWARD ZUCKER: Well, we review the

CDC guidelines on a regular basis with regards to the PPE issue, a 90-day supply.

The reason we have a 90-day supply in place is because, if we start to recognize that there is a problem after 30 days, whether based on guidance from the CDC or our own guidance, we will be able to immediately adjust and make sure that we have enough PPE.

I gather what -- the CDC guidance is just one -- we follow that, but we also look internally.

And that's why the governor has said, let's have enough PPE.

ASSEMBLYMEMBER QUART: Well, Dr. Zucker, I'll just pick up on your answer.

You said "immediately adjust."

And I think that may, or very well may, become relevant, because, as you're well aware, Vice President Pence set forth that the CDC guidelines could, or would, change.

So what is the mechanism that you've implemented on changing guidelines, in light of any change on CDC guidelines, or, change of circumstances in the hospitals themselves?

COMM. HOWARD ZUCKER: Oh, that's what I'm saying, with a 90-day supply, a 3-month supply is a

significant amount of PPE.

The issue here is that, if we start to see an uptick in cases, we will adjust accordingly.

This is not sort of a, you know, on/off switch.

If we start to see a little bit of a change, or more of a change, then we will go back and look at the guidance that we have, as well as any of the recommendations the CDC have, and adjust it, to be sure that we meet the demands of those in the hospital.

ASSEMBLYMEMBER QUART: Well, you mentioned sufficiency of PPE, so let's delve into that a little bit, Dr. Zucker.

As the pandemic set forth, there seemed to be a disconnect, at least from my perspective, between hospital administrators, what they were telling you, and nurses who were on the nightly news, saying, very specifically, that there was not enough PPE equipment within the hospitals.

And they referenced that, and memorialized that, in the lawsuit, all those complaints, in April of this year.

Did DOH have an acute awareness in real time of the situation on hospital floors, maybe something

different than what hospital administrators were telling you?

COMM. HOWARD ZUCKER: So a couple things on that.

One is: Just because something is reported doesn't mean those are the facts of what is actually happening and what's reported on the news.

I actually have spoken to the hospital administrators on a regular basis during the time that was going on, but, not only talking to the administrators, because you just raised that, I also spoke to the physicians and the nurses in many of the hospitals, and the leadership, and asked these questions.

And there was, we provided 24 million pieces of PPE, and there was available PPE to all those who needed it.

Granted, there were different policies that were put into place about how to preserve some of the PPE equipment. But we were pushing also to get more PPE.

I can tell you that, in those conversations with those physicians and those nurses, they said, we have the PPE that is needed.

If there was a problem, they should come back

to us and we make sure that it's available.

So I'm not -- sorry.

Go ahead.

ASSEMBLYMEMBER QUART: Since I only have a couple seconds left, in response to your -- the last part of your answer:

As you know, my colleague Assemblymember Reyes passed legislation, Chapter 117 of the laws of 2020. It's, essentially, a whistleblower protection for those who come forth and make complaints that might be contrary to those by administrators within the hospital.

Does DOH have any normal procedures in place, if there's another wave, for whistleblowers coming forth, taking in that information and processing it and responding to it in a timely fashion?

COMM. HOWARD ZUCKER: Well, we always respond.

If there's any concern, whether it's in a hospital or any other Article 28 facility, and someone brings it to our attention, we immediately investigate that.

If someone had a concern, whether it was during the previous months of this pandemic, or going forward, we will investigate it and act

accordingly.

SENATOR RIVERA: Thank you, Commissioner.

Thank you, Assemblymember.

Next from the Senate, we have Senator Gallivan recognized for 5 minutes.

SENATOR GALLIVAN: Thank you, Chairman.

Good morning to all the members of the panel.

Dr. Zucker, I want to talk a little bit about the discharge and transfer of patients.

And we go back to Executive Order 202, which the governor issued on March 7th, dealing with rapid discharge, transfer, and receipt of patients.

Could you explain what that order did?

COMM. HOWARD ZUCKER: I'd like to know a little bit more. I have to -- you know, there are a lot of numbers on a lot of orders, so I need to find out which one it is.

SENATOR GALLIVAN: So this deals with rapid discharge, transfer, and receipt of such patients at hospitals and nursing homes.

COMM. HOWARD ZUCKER: Well, patient -- I'm not sure what you mean by "rapid transfer."

The fact is, if a patient is ready to move from the hospital, and meets all the clinical criteria, and -- then the patient can be

transferred.

We have many different guidance documents that have been put into place over the course of this pandemic.

I'm happy to review that particular document and get back to you.

SENATOR GALLIVAN: Well, I'm not sure what the governor meant by "rapid transfer" either, which is why I asked the question.

COMM. HOWARD ZUCKER: Well, I will tell you -- I just will tell you that, at that moment in time, we were seeing, as I was going to mention in my opening remarks, 140,000 potential cases.

And the goal was to make sure that people who were better, and able to move, should be moved to the appropriate facilities.

And that was just what we needed to do to make sure we had enough beds for all the patients who potentially could come in.

But I will go back and look.

SENATOR GALLIVAN: Are you able to talk about the type of coordination that exists between hospitals and nursing homes?

COMM. HOWARD ZUCKER: Sure.

Well, there's always coordination between

hospitals and between all other Article 28 facilities.

And so during this period of time, I mean, we'll start with the hospital issue. The nursing home issue we discussed last week.

But on the hospital issue, the governor had said, right at the beginning of this, that we need to level -- a level setting, to be sure that there is a possibility to move a patient from one hospital to another hospital, independent of whether they're in the same system.

Many times patients move within the system, but we also move them across systems, in an effort to be sure that all patient needs were met.

And the same with any other needs of patients from one facility to another.

SENATOR GALLIVAN: So there was another order on May 10th, another executive order, and that prohibited hospitals from discharging patients to a nursing home, unless first certified by the nursing home administrator that the facility could properly care for the patient. And it required the hospitals to perform a COVID test on the patients prior to discharge.

How did that order come about?

COMM. HOWARD ZUCKER: So -- I mean -- well, I'll answer that, but then I also want to mention that we did -- we did discuss all of this the last time I was here, when I discussed the nursing home issue.

The May 10th issue is that we now had the capability to do more testing. And so that was the decision, to do testing before someone left the hospital. That was what the purpose of the May 10th order that was put forth.

But we have already discussed the issues of the nursing homes, whether it's that issue or other issues.

And I'm really here to talk about the hospitals, and to focus on the hospitals' challenges that they had during the time of this crisis, and going forward as well.

SENATOR GALLIVAN: Do you have an idea of how many patients were discharged [indiscernible] hospitals, back into the nursing homes, during this pandemic.

ASSEMBLYMEMBER GOTTFRIED: Senator, Senator, excuse me, if I could interrupt.

We're really trying to focus in this hearing on hospitals, and not nursing homes.

We did 23 hours on the topic of long-term care.

I would ask that questions along this line, send them to me and Senator Rivera in writing. We will send them to the commissioner, and we will get answers.

But we really need to focus today on -- strictly on hospitals.

SENATOR GALLIVAN: I'm focusing on the process that hospitals were directed to follow in order to discharge people back to nursing homes.

And I'd also like to know how many nursing home patients were transferred to the hospital, when they're in the hospital, and subsequently died of coronavirus?

COMM. HOWARD ZUCKER: This is the issue that I addressed a week and a half ago.

I said, I think we have litigated this issue, and I said that I will provide you the information once I have an opportunity to review it and I've made sure all that data is accurate.

And I'm happy to do that, and I will do that.

But if there are specific questions regarding the hospitals and those issues, I'm happy to answer them.

SENATOR GALLIVAN: How many ventilators did the State obtain from upstate hospitals and transfer to downstate hospitals?

COMM. HOWARD ZUCKER: I have to look at the exact number.

On the ventilators, I know that the issue was to be sure there were enough ventilators available to all of the patients that needed them.

We looked at this issue when we started on the challenges that we faced.

We were concerned that we were going to end up, where the potential for splitting ventilators, and what would be needed; BiPAP machines being converted to ventilators.

And I can take a look and see if I have that number with me.

Give me a second, if I have it here.

SENATOR RIVERA: I'll give you a couple more seconds since there was a period there when the time kept running.

COMM. HOWARD ZUCKER: So the department -- the department deployed 2600 ventilators to hospitals.

And the exact number from upstate, I'd have to look that one up. I don't have that exact

number.

SENATOR GALLIVAN: The very last question also has to do with [indiscernible cross-talking].

SENATOR RIVERA: Very quickly, please.

SENATOR GALLIVAN: Was anybody without a ventilator that needed one?

COMM. HOWARD ZUCKER: No.

SENATOR GALLIVAN: All right. Thank you.

COMM. HOWARD ZUCKER: In fact, even during our peak, when there were 4449 patients intubated, it's an unbelievable amount of patients intubated, they all, who needed a ventilator, got a ventilator.

And, now, there are only 60 people in the state of New York ventilated.

We went from 4500, essentially, down to 60.

SENATOR RIVERA: Thank you, Commissioner.

SENATOR GALLIVAN: Thank you.

SENATOR RIVERA: Thank you, Commissioner.

Assembly.

DR. JAMES MALATRAS: [Indiscernible] 30 seconds more, because I think the ventilator point is a really important point.

SENATOR RIVERA: However, we will have to -- but we will have to go to the next -- let's go to the Assembly.

You'll have an opportunity, I'm sure, to answer it at a future date.

ASSEMBLYMEMBER MCDONALD: The Assembly will recognize me.

And, Dr. Zucker, Dr. Malatras, and Dr. Gareth, thank you for being with us.

Executive orders, obviously, there was plenty of them issued.

Of course, we don't hear too much about the ones that are working. We only hear about the ones that people aren't happy about.

I'm kind of curious, from a professional standpoint, you know, obviously, the governor was very direct about trying to recruit doctors and nurses that were retired to come back in. We allowed medical students to start to practice.

Was that a significant help to the hospital systems during this process?

Was there a lot of participation from those retired professionals, and, obviously, were many of the young professionals able to start?

COMM. HOWARD ZUCKER: So we did many -- we did many things to address this.

We had volunteers, we had 95,000 volunteers, available. And 15,000 of those came from other

areas, came from upstate and in the state, as well as elsewhere, to help out in the downstate area.

We had some of the medical students -- or, medical students graduate early, to bring them in.

This was all helpful.

When you have a system which is so stressed during this kind of a crisis, which is completely unprecedented, you need to utilize all the resources you have, and one of the major resources is human resources.

So they were extremely helpful.

If your question is, were they helpful and beneficial? Absolutely.

DR. JAMES MALATRAS: We had 30,000 volunteers, 30,000 from out of state.

I think we had nearly three or four hundred of the facilities access our portal and use those volunteers.

And it was, as the Commissioner said, absolutely essential.

And where it was helpful was, staffing agencies exist in the world, but there's fees and other things.

But the State's mechanism, [indiscernible] quickly and expeditiously done without the overhead

and the fees, and those types of things.

So it was used quite regularly by the hospitals, nursing homes, and other facilities.

ASSEMBLYMEMBER MCDONALD: So I'm going to speak for upstate for a little bit.

And we understood during -- as the crisis was unfolding, capacity in the hospitals in downstate were a big issue.

And, obviously, it was big news up here when the first ambulance showed up, and -- from patients from New York City were here at Albany Med.

Do we have any idea of how many patients were transported from downstate to upstate during the course of the pandemic?

COMM. HOWARD ZUCKER: There were transfers that we facilitated through ambulances and -- as well as working with FEMA. There was a handful that did go from downstate to upstate.

But the goal, as the governor mentioned, was to see how to move patients within the system that they have, and to move them. And we were able to do that.

And why would you take someone and move them upstate if you don't have to?

I'm going to speak now as a clinician.

The worst thing you could possibly do -- everyone thinks you put someone in the back of an ambulance and just move them, and it's no big deal.

But, in reality, that is extremely dangerous to move somebody. You're putting them in, if they're intubated, the tube slips, something happens, you don't have the resources to help them, you don't have the medications, you don't have the backup systems that are available, the support there.

So you don't move people unless you really need to move them. And if there's a way to move them locally, you do it that way.

And that's the smartest thing you can possibly do, and that's why we didn't move them all [indiscernible].

ASSEMBLYMEMBER MCDONALD: I agree with you 100 percent.

And that's the comments I was saying to people: They weren't move them unless they truly had to move them.

I think, and this is just to be noted, obviously, with the restrictions on non-emergent processes, a lot of our upstate hospitals lost a lot of opportunity to continue to serve their

constituents. And a lot of these upstate hospitals have been left out in regards to support.

And I think that's something we need to be very mindful of, because I've heard from all of our upstate hospitals that they are bleeding tremendously, financially.

Actually, Dr. Malatras, I know you wanted to mention something about ventilators, so I'm going to give you 30 seconds to say that.

DR. JAMES MALATRAS: We kept very close data analytics on every ventilator in the state of New York, to make sure every hospital had the ventilators they needed.

And the most important one that we [indiscernible], of course, [indiscernible] system in New York City, which had the largest impact [indiscernible] at COVID. And we knew, exactly to the date, how many excess ventilators they had.

So whether it was downstate or upstate, we made sure, in the spirit of cooperation and collegiality of the hospitals systems working together, that no hospital was left without the necessary ventilators and other materials they needed. And worked quite well.

The Upstate Health Association hospitals

worked really well together with the downstate facilities.

So that process, where everyone always had the ventilators they needed. But, we were pushing, of course, for more ventilators because there was a dramatic need across the entire [indiscernible].

ASSEMBLYMEMBER MCDONALD: Thank you.

I'll just make a closing comment, and, Dr. Zucker, really, it's not for you; it's probably for the others who are listening.

PPE, it's very clear, after 23 hours of hearings, we need to be able to, New York State, provide for our own.

We need to find a way to do it in a cost-effective manner.

What's not being discussed is the cost to these hospitals. And upstate and downstate are enduring, buying this PPE from China.

Thank you.

SENATOR RIVERA: Thank you, Assemblymember.

Now recognize Senator O'Mara for 5 minutes.

SENATOR O'MARA: Thank you, Chairman.

Good morning, gentlemen. Thanks for being here.

I want to credit the State and their response

to ramping up hospital beds that were needed. I think an outstanding job was done in regards to that.

And we had a great outpouring of health-care workers that came to New York, to help us, from across Upstate New York, from states across the country, frankly, to come in. And I thought it was very well done.

I was disappointed that the health-care workers being paid in New York City were hit with our high income taxes, which was reported upon, and certainly shocked them, and opened their eyes to the real state of taxation in New York.

But I'd to like to ask you gentlemen: Is there anything being done to help those health-care workers that got slammed with the extra taxes, recoup those?

COMM. HOWARD ZUCKER: That is something we will -- we can look into and get back to you on.

SENATOR O'MARA: All right.

With the beds that were ramped up in the hospitals, what was the peak occupancy during the height of this, and when was that?

COMM. HOWARD ZUCKER: Sure.

So, on April 12th, there were 18,825 patients

in the hospital.

Now we have in the 500 range of patients in the hospital.

At that time, we had over 5,000 individuals in the ICU, and we had, as I mentioned, 4449 people intubated. And now we have, down, 60 people intubated.

We have come down that curve amazingly well.

And when you look at other parts of the country, and I get calls, and I speak with other health commissioners, they ask, on a regular basis: How did New York do it, and what do we need to do?

This was a true collaborative effort across the entire health system to make this happen.

SENATOR O'MARA: And you still are not prepared today to tell us how many deaths occurred in hospitals from patients transferred from nursing homes?

COMM. HOWARD ZUCKER: As I mentioned in the last hearing that I did, that I'm working on making sure that some of those numbers are not double-counted. And I promised to get back to you on that.

SENATOR O'MARA: Will you agree to appear before these committees again in the future once

that information is available?

COMM. HOWARD ZUCKER: We will be able to provide you that information as you need it, and we can discuss it at that point.

SENATOR O'MARA: With regards to the order to send hospital patients back to nursing homes, Upstate New York hospitals didn't have the occupancy problems that New York City hospitals had.

And in New York City, shortly after that order, we had the "USS Comfort," the Jacob -- the Javits Center, and the Good Samaritan Hospital in Central Park.

Why were those facilities not utilized as overflow for these COVID patients to go back to [indiscernible] stay in the hospital?

And why couldn't they stay in upstate hospitals where there wasn't full occupancy?

COMM. HOWARD ZUCKER: So let me see if I understand your question, because you broke up a little bit in there.

As I understand what you're asking is: Why could some of the -- why did patients go to the Javits and the "Comfort" versus going to upstate facilities?

Is that what you're asking?

SENATOR O'MARA: No.

Why did nursing home patients that you were eager to open hospital beds for, rather than returning them to their nursing home, why didn't they go to the Javits Center or the "USS Comfort" or the Good Samaritan Hospital in Central Park?

[Indiscernible] same token, why did upstate hospitals that didn't have an occupancy problem, why didn't they remain in the hospitals?

COMM. HOWARD ZUCKER: So, you know, as we mentioned before, that we've gone through this in the nursing home hearing, but let me just reiterate: That hospital -- the Javits and the "Comfort" were designed for certain purposes.

And the fact is, that an individual who needs -- a resident of a nursing home needs care, a certain type of care, was not going to be provided at a Javits or a "Comfort." That's not what they were designed for.

But I discussed this all last week, the exact issues there.

And regarding upstate, there was -- there were appropriate care that needed to be provided at the hospital. And they go back to their -- their nursing homes, then they return there.

GARETH RHODES: If I could say something as well, the Javits Center, for example, the restrooms that were there were not in the individual rooms. They were provided on the -- in a trailer of a large semi-truck, a vendor that came in.

The Javits Center was not an appropriate place for a patient or a resident who had dementia, for example.

That we -- every one of these transfer decisions was based on the individual patient, what their individual patient's needs are.

And [indiscernible] find -- you never want to put a patient in a facility that isn't able to provide the proper, the adequate, care.

COMM. HOWARD ZUCKER: You know, Senator, the other issue here is that, regarding upstate, we understood -- when this began, and this was happening in New York City, we did not know how this was going to spread.

Was this going to stay in that area? a handful of counties? Was it going to get worse?

Look what has happened across the country now.

And so we need to be prepared.

And this is why the governor canceled

elective surgeries and made sure that we had the availability of --

SENATOR RIVERA: Thank you, Commissioner.

Thank you, Commissioner.

Assembly.

ASSEMBLYMEMBER MCDONALD: I want to recognize some assemblymembers that have joined us: Linda Rosenthal, Marianne Buttenschon, Nathalia Fernandez. I think I already mentioned Steve Cymbrowitz. And I think Andrew Garbarino might be, I'm getting a second.

And we will now move on to Assemblymember Ron Kim for 3 minutes.

ASSEMBLYMEMBER KIM: Thank you for joining us today, Commissioner Zucker and Dr. Malatras.

Due to my limited time, I have a few questions to which I appreciate a yes-or-no response.

Would you agree that, when we hit the peak of the COVID mountain, we were in full triage mode and didn't know how to fully prevent the spread of COVID or arrange the best care for COVID patients?

COMM. HOWARD ZUCKER: See, this is where I can't answer yes or no, because these things are not --

ASSEMBLYMEMBER KIM: That's fine, that's fine.

Would you agree that, during these panic times, hospitals were [indiscernible] for direction and guidance from this administration, and that every policy decision played a key role in the way health-care facilities treat, diagnose, and arrange care for COVID patients?

COMM. HOWARD ZUCKER: They were looking for guidance from so many different sources, and we were one of them, the government. And we were a key role -- played a key role in this, obviously.

ASSEMBLYMEMBER KIM: Fair enough.

Is it possible, then, under these circumstances, state policies could have led to unintended consequences and outcomes?

COMM. HOWARD ZUCKER: There's always the potential for something that one does not anticipate is going to happen. But it's not like a policy is put into place, expecting an unintend -- an outcome that was not --

ASSEMBLYMEMBER KIM: But it's certainly possible.

That's why it's called "unintended."

COMM. HOWARD ZUCKER: [Indiscernible]

pandemic, where you don't have all the facts, anything is possible.

GARETH RHODES: State policies [indiscernible cross-talking] --

ASSEMBLYMEMBER KIM: Sure.

GARETH RHODES: -- when you have --

[Multiple parties cross-talking.]

ASSEMBLYMEMBER KIM: So, Commissioner Zucker, are you aware of any hospitals complaining to your department that nursing homes were intentionally transferring dying COVID residents to hospitals at around the same time states stopped counting these transfer deaths?

COMM. HOWARD ZUCKER: You know, this goes back to the question I keep -- or, the statement I keep making.

But, again, no, we do not have any reports that were brought into -- into, at least to me or to the department, about this.

But we have, as I said, litigated the nursing home issue for, you know, multiple hours in the past.

ASSEMBLYMEMBER KIM: Okay, that's fine.

My last question, Commissioner Zucker: Is the department of health investigating any transfers

of COVID patients between hospitals and other health-care facilities, and, vice versa, from March 25th to now, that could have led to mistreatments and misdiagnosis of these patients or to spread of COVID to others?

COMM. HOWARD ZUCKER: So let me answer that by saying that we are in the middle of a pandemic.

After there is an event, whether it was when we looked at the measles issue, or whether there was the H1N1 situation back in 2009, even though it was before my time, you do an after-action items report, and you look at all the things that have transpired.

We are in the middle of this, we are still managing it.

I know that the hearing is going on, but I can tell you that my team is sitting in the offices until 2:30 in the morning the other day, working [indiscernible cross-talking] --

ASSEMBLYMEMBER KIM: If we're in the middle of it, and we're all going to take a victory lap [indiscernible cross-talking] --

COMM. HOWARD ZUCKER: -- [indiscernible cross-talking] --

ASSEMBLYMEMBER KIM: -- as if this was -- you know -- thank you.

SENATOR RIVERA: Thank you, Assemblymember.

Thank you, Commissioner.

I'll recognize myself for 5 minutes.

Thank you all for being here today.

I want to focus on safety-net hospitals, particularly since what we're talking about here, we all recognize, and it has been said by many of my colleagues, that there are a lot of things that we did not know about this disease, and when we're talking about the peak of it all, we're talking about the first three weeks of April, really, where, like -- when -- when things were extremely bad.

I want to talk about safety nets, and I want to focus on, we all were in a moment of triage.

And I want to talk about how -- I want you to be on the record about how the State calibrated, particularly because, if we're talking about, for example, there's a story on April 3rd of this year, that spoke specifically about something that we all -- that we all knew, and at that moment it was very clear, people of color and people who were served by safety-net hospitals were being struck far worse than anybody else.

Right?

And so the next three weeks, from April, were

key in -- in being able to control this.

I wanted to talk -- I want you to talk about how the State calibrated the resources to go to safety-net hospitals; I want to talk about how that is happening, because, when there is -- as we're still in the first wave, but when the second one hits, or when the other bump hits, we're still going to get worse -- we're still going to get hit worse in places like The Bronx, and other places that have safety-net hospitals.

So I want you to talk about how the State calibrated resources for those institutions, please.

COMM. HOWARD ZUCKER: So there's a couple of parts to that.

One is, the issue of the need to be sure that the resources are available, to whether it's -- you named The Bronx, you pick the area, it doesn't specifically matter, where there are individuals who are more challenged by this, put it that way.

And we realized this -- by looking at some of these ZIP Codes, we realized that the antibody levels were higher in certain areas of the state.

And I bring up The Bronx because it was higher, and it's your area.

SENATOR RIVERA: Yes, sir.

COMM. HOWARD ZUCKER: And we realized [inaudible] realized that the individuals that live in that area were also those who ended up in the hospitals in that area, and were affected.

We have reached out to all the hospitals. We are trying to be sure that the resources are available, both all the things we mentioned -- the PPE, the staffing, the equipment -- to be sure that, if there is an uptick, or if there is a, you know, surge, and, hopefully, it doesn't happen, that those hospitals who provide the care to those communities have what they need.

And this is an ongoing discussion with those -- the leadership of those hospitals, as well as the associations.

And --

SENATOR RIVERA: And I want to -- I just want to be on the record that it's just -- and that is -- and that is good.

But I just want to make sure that we're on the record, saying, that it's not just -- certainly, the resources that are needed during triage times, I'm very -- that is very good, that that focus is on there.

But there has to be some commitment from the

State, to make sure that we stabilize institutions which are safety-net institutions to begin with.

They were in crisis before the crisis.

And I know that you recognize this, but I want to make sure that there is a recognition on the record from the administration that there needs to be a commitment, to making sure these institutions are maintained, because, in times like crisis -- in time of crises, these are the communities that get hit worse.

We're not just talking about safety-net institutions in The Bronx. Certainly, safety-net institutions all across the state.

So I just want to make sure there's a commitment on the record, that it's not just about the resources that are needed doing triage --

Which I am very, very, thank you for that.

-- but it has to be a long-term commitment, to making sure that these institutions can continue to thrive because, after the crisis is gone, there is still crisis there, because, as I said, there was a crisis before the crisis.

COMM. HOWARD ZUCKER: Well, I think there's a key point here, and someone asked me the question: What did we learn from -- so far from this pandemic?

SENATOR RIVERA: Did you recalibrate -- did you recalibrate?

That's what I'm talking about.

COMM. HOWARD ZUCKER: Right, right.

And I think one of the things we learned, I mentioned this before, is that it showed the health disparities that exist in society, and we need to address them, and we are addressing them.

And I will mention that there's -- for the financially-distressed hospitals, there is a billion dollars -- a little over a billion dollars of the $4 billion that came in that was going to those hospitals.

And we also transferred -- that we transferred patients from some of these safety-net hospitals during the -- the point of the surge to other facilities, to make sure that those patients' needs were met during that time.

I know that's retrospective.

And I know what you're asking about, looking prospectively, and we are.

SENATOR RIVERA: And just one -- I just want to make sure that we were -- again, that there's a recalibration when necessary. That we put the resources where are most necessary.

And if we recognize, as has been -- as the data speaks for itself, that it is Brown and Black communities, poor and working-class communities, that are get -- that got hit worse by the crisis, that those institutions which are safety-net institutions, for those communities, get the resources that they require, that they need, during this crisis.

COMM. HOWARD ZUCKER: I hear you [indiscernible cross-talking] --

SENATOR RIVERA: I just want to make sure that it's on the record.

Thank you.

Assembly.

ASSEMBLYMEMBER MCDONALD: Senator, I will recognize now the ranker for health in the Assembly, Kevin Byrne, for 5 minutes.

ASSEMBLYMEMBER BYRNE: Thank you, Chair.

Thank you, Commissioner, for being here.

I know it's 11:00.

How much time do we have with you left? Because I just want to be as quick as possible.

COMM. HOWARD ZUCKER: I have two hours --

ASSEMBLYMEMBER BYRNE: I know you're a busy guy, you've got an important job, but, what are we

looking at?

COMM. HOWARD ZUCKER: I think I have two hours, so I have one more hour left.

ASSEMBLYMEMBER BYRNE: Okay.

So I'm going to try to keep plowing through.

I hope my colleagues get to ask all the questions they want.

I'm glad you talked about hospital capacity. That was something where I expected we were going to hear a lot about.

And when the governor and you, and we had those -- plenty of those press briefings (frozen video).

SENATOR RIVERA: Assemblymember Byrne, I think we're frozen.

Freeze the time, please.

Let's see if he comes back.

Assemblymember Byrne, we'll give you a couple more seconds.

We will come back to Assemblymember Byrne.

SENATOR TEDISCO: Senator? Senator?

It's Jim Tedisco.

Could I have 3 minutes at some point?

SENATOR RIVERA: Sir, we will get to you, Senator Tedisco, yes. Hold on a second.

So will -- do you have another assemblymember on deck?

ASSEMBLYMEMBER MCDONALD: Yes, we do.

Ranker Brian Manktelow.

SENATOR RIVERA: Got you.

We will return to Assemblymember Byrne.

Thank you.

ASSEMBLYMEMBER MANKTELOW: [Inaudible.]

SENATOR RIVERA: We can't hear you, Assemblymember.

It seems that technical -- all right.

So I'm going to go --

ASSEMBLYMEMBER MCDONALD: Let's go on to --

SENATOR RIVERA: [Indiscernible cross-talking] let's go to Senator --

ASSEMBLYMEMBER MCDONALD: Okay.

SENATOR RIVERA: -- let's go to Senator Metzger.

Recognize Senator Metzger for 3 minutes, please.

SENATOR METZGER: Thank you, Mr. Chairman.

And thank you for joining us today, Commissioner.

I also want to express my appreciation to you and your staff during this unprecedented crisis.

As Senator Skoufis said, you know, the facts on the ground were really changing minute to minute.

The crisis took an enormous toll on hospital workers; the incredible physical and mental stress that they endured during this crisis.

And I want to ask:

What is being done to make sure that they get the support and help they need?

And whether you're considering, you know, mental health and care for these workers and planning for a future surge?

That's one question.

I'll get all my questions out.

I -- turning to PPE:

I know at least one hospital in my district is having a hard time obtaining the necessary masks, a 90-day supply, specifically small N95 masks, which was a problem throughout the most challenging part of this crisis.

So I would like to, you know, hear what you recommend on that score.

And I also have a rural hospital that has a serious problem with having sufficient storage for 90 days of PPE.

And I imagine this is a difficulty for other

hospitals as well.

And want to know if you have recommendations for addressing that, or if this has come up, and how they can address that?

Thank you.

COMM. HOWARD ZUCKER: So on the mental-health issue, we do have a COVID mental-health hotline that is available, which has been available since the -- pretty much, the beginning of this pandemic.

I've also spoken to the office of mental health about some of these issues.

And I have to tell you, Senator, I've actually spoken to my colleagues in the hospitals, and some of the things that you hear, I personally heard from nurses and doctors, and the challenges that we read, that unfortunately tragic story about the doctor at Columbia who committed suicide.

So, I hear you.

And I think it's a really important issue, and it is being addressed, and will be addressed going forward.

Regarding the PPE -- Jim, do you want --

DR. JAMES MALATRAS: No, we understand that many of the facilities have challenges, but we think it's really important, as many of your colleagues

have noted, the issues on PPE.

And that's why we're working with the health-care associations, to make sure every hospital has what they need to build it up.

And I just wanted to go back to one point, because it was raised about health-care facilities.

Even during the crisis, when we did hear about some challenges in individual hospitals, the governor required that each facility give a nurse an N95 each day. Right?

So we did adjust that policy when we heard from, you know, the nurses, the heartbeat of health care to us.

So when we heard those challenges, we worked very closely with those folks.

And on the PPE, many of us at the table today, we, literally, took calls from individual hospitals for help on the PPE side.

So, we were actively engaged at the whole time.

SENATOR METZGER: Sorry, but, time is up, but the storage is a big issue, so I hope you can address that at a later time.

Thank you.

SENATOR RIVERA: Thank you, Senator.

Now we'll try Assemblymember Byrne.

Is he back?

If you -- well, if you have somebody in the Assembly --

ASSEMBLYMEMBER MCDONALD: Yep, we will -- I don't see Byrne or Manktelow, so we'll go to Assemblymember Kevin Cahill.

SENATOR RIVERA: Thank you.

ASSEMBLYMEMBER MCDONALD: 3 minutes.

ASSEMBLYMEMBER CAHILL: Hello, Commissioner, and Gareth and Jim. It's good to see so many of my homies here today on the screen.

Gareth is a Kingston resident, and, Jim, of course, hails from the great village of Ellenville.

Commissioner, thank you once again for joining us.

I would like to talk for a few moments about the rest of health care, not specifically COVID.

But, we can start by talking about the fact that many health facilities around the state, including here in the Hudson Valley, were designated as COVID centers. And, as a result of that, the hospitals that were conducting business in other areas had to discontinue that.

So here in our community, that meant that our

well-respected and much-needed psychiatric inpatient care center was moved to another community. And the people that rely on that no longer had that available to them in this community, and that created incredible dislocation for those families.

And I'm sure similar compromises occurred in other communities, where facilities were, for all intents and purposes, commandeered to be on reserve.

And, by the way, I'm not questioning that decision. I think it was a good decision.

What should be -- what [sic] should we reasonably anticipate that that decision will be revisited; what will the result be?

And my second question in that regard is: What impact does this have on the long-term certificate of need?

For example, the Hudson Valley Health Alliance hospitals have a new certificate for 170-so beds, down from about 500 combined in the previous iteration.

And one-third of those beds were dedicated to the psychiatric unit, and now that psychiatric unit has largely been moved to another city.

When can we expect those facilities to be restored?

And when will the department of health once again be re -- be enforcing certificates of need?

COMM. HOWARD ZUCKER: So on the issue of the behavioral-health issues, we're working with the office of mental health to address that, to make sure the facilities are -- that meet the needs of the community are able to be up and operational again.

I can't speak specifically about the certificate of need.

As they come in, we will look at them, and see where we are.

I think one of the things that has happened, there's a sense that, that because our numbers are so low in New York State, that this has gone and it has passed.

But, we are constantly addressing the potential of an uptick of cases. And we have to be sure that we keep the buffer in place, to be sure that we meet any of those challenges that may come to us in the fall.

So I don't want to say we're not going to do this.

Sorry?

ASSEMBLYMEMBER CAHILL: Sorry, before I run

out of time, I recognize that we have to deal with an emergency with emergency measures.

My concern is the longer term, and restoring those services, those needed services, to our community.

COMM. HOWARD ZUCKER: I got it, and it stays on the radar, and we'll make sure that that doesn't get dropped.

ASSEMBLYMEMBER CAHILL: Thank you.

SENATOR RIVERA: Thank you, Assemblymember.

Thank you, Commissioner.

Next we have, recognize Senator Brad Hoylman for 3 minutes.

SENATOR HOYLMAN: Good morning.

Thank you, Commissioner.

Thank you, Jim and Gareth.

And from my constituents, I just wanted to really thank you for all your work.

I had two quick questions.

One: We know that, back in April, the organization Samaritan's Purse, led by that notoriously homophobic pastor, Franklin Graham, opened up a field hospital in Central Park through a partnership with Mount Sinai.

You know, he has a long history of homophobic

and transphobic comments.

He called LGBT activists "immoral." He said that being gay or trans is detestable. He claimed that Satan was behind the fight for equal rights.

He also required employees to sign a statement of faith, which, essentially, reaffirmed their homophobic views, before working in the field hospital.

And Samaritan's hospital continued to work at that location, really, until May 5th, meaning, that they operated for more than a month.

In your review that you're planning on taking, will you commit to looking at how the decision-making was made to allow what, by most accounts, is a disreputable organization, to set up an encampment on public property in Central Park?

COMM. HOWARD ZUCKER: So regarding how that was set up, this was an agreement between the hospital and that organization. Obviously, the State was not involved in that at all.

So I just want to be on the record about that.

But as we move forward, and as we look at all the issues after this pandemic is over, we will address all of them, including the issues of a field

hospital, and the relationships and how it was set up.

I'm happy to do that.

SENATOR HOYLMAN: Thank you, because it -- I think for the LGBTQIA community, it has, you know, left a bitter taste in our mouths, that an organization was using this as, essentially, a paid, you know, advertisement for proselytizing its homophobic views.

And then, secondly, I just wanted to follow up on health-care workers who are at the center of this pandemic.

We still don't have a sense, as policymakers, how many were infected or died.

Will you be releasing that data at some point, with specific numbers on infection for mortality, so we can move forward on protecting them should, God forbid, we endure another wave of the pandemic?

COMM. HOWARD ZUCKER: So I think there's two parts to that.

One is, that, yes, we're always looking at these numbers, and as I have mentioned previously, to get the accurate numbers, and exactly what happened.

And I -- you know, I really feel for all the health-care workers.

One of my colleagues died; one of the doctors I worked with died in one of the downstate hospitals. And there are others across the country that I've heard about, and others that were in the ICU that we know about.

So we will look at those numbers, and to make sure, going forward, that we address that.

So I have to say that -- oh, sorry. Time's up.

SENATOR RIVERA: Thank you, Commissioner. Yep, yep.

SENATOR HOYLMAN: Thank you for your good work.

Thank you --

ASSEMBLYMEMBER MCDONALD: The Assembly --

SENATOR HOYLMAN: Thank you for [indiscernible cross-talking] --

ASSEMBLYMEMBER MCDONALD: The Assembly now recognizes again, Member Kevin Byrne.

Welcome back.

SENATOR RIVERA: Second at bat.

ASSEMBLYMEMBER BYRNE: Thank you, and apologies for the disruption. Lost power for a

little bit.

But, Commissioner, again, thanks for being here.

I want to try to be as effective and efficient with my time as possible.

We talk about flattening the curve, flattening the curve. We talked about reducing density.

It was almost a mantra in the governor's daily press briefings.

Something we also heard the governor and the administration talk about a lot was increasing hospital capacity.

You spoke about it in your testimony today.

I don't hear a lot of discussion about that now, since, quite frankly, we've successfully reduced the infection rate. We've -- we're in a better position now than we were, perhaps, in March, April, May.

But, increasing hospital capacity, I believe there would be benefits for that, not just during a pandemic, but, perhaps, before and after a pandemic.

In fact, some folks have phrased increasing hospital capacity as "raising the ceiling."

So we're flattening the curve, we're raising

the ceiling.

The Mercatus Center, which is a more market-based group, came out with their Hope 2020 report. It was a pre-release. It was not peer-reviewed yet. But they do rankings for states across the country, based on a bunch of different factors. And it's based on health-care openness, access, transparency.

And they, sadly, rank us pretty low on this bar.

And I'm not doing -- I'm not saying that as a criticism, but my point being, I think there's a lot of room for us to improve, I think there's always room to improve, to increase access to care.

And the governor has had some sweeping powers, with these disaster powers, with directives, suspending state laws, as a means to increase access to hospital capacity.

Which ones of those did you find to be the most effective?

Which ones are still in effect today?

You talked about hospitals doubling capacity.

When did that expire?

And, what lessons have you learned with these directives, that we can continue, post pandemic, and

in preparation for a second surge?

COMM. HOWARD ZUCKER: That's a very pat question. I'll answer part of that. I know Jim has some comments as well.

First, the increase in capacity, this is still in effect. We are 64 -- we increased it by 64 percent. We had 27,000 beds that we increased during the surge.

There are many lessons that we have learned from this pandemic.

There are many lessons, going forward, that address the whole health-care system, you raised, not just about a pandemic, but, you're right. We could have a terrible flu season one year, or we could have other problems that can occur. And we have addressed it.

So the concept of how to surge and flex is something that we have now developed, put into place, and we will be able to activate it whenever is necessary in the future.

The concept of how to move patients from one hospital to another, and activating this care-coordinating system, could be up and running again.

The concept of how to develop other

facilities, and what we would need to do, has already been worked through. The blueprint is there, we just need to implement it again.

So that's part of it.

I know Jim had some other points you wanted to raise?

ASSEMBLYMEMBER BYRNE: For either of you, just because there's limited time, if there's specific regulations that were suspended through the governor, that you found to be effective, that perhaps we should consider, moving forward, if there's any specific things that you can cite, that would be helpful too.

DR. JAMES MALATRAS: We are looking through those regulatory pieces right now, Assemblyman.

And we want to also note that we're tracking hospital capacity very closely right now on our dashboard, which everyone in the public is following.

We have about 30 percent of our hospital beds available in the state right now, including about 40 percent of our ICUs.

So we're looking at that not only statewide, but regionally, so we know what [indiscernible] happen.

I think the important regulation you asked about, which we've memorialized it, it was originally done in an emergency context, but we put it into a regulatory context, is the Surge & Flex, so we can quickly adapt and have more beds.

So we are watching right now, very closely, how many hospital beds are not only in each individual hospital, but also how many are regionwide, so we are -- we are concerned about that as well one. We're noting those things very closely.

And one of the requirements we had to begin reopening, as we all know, is that hospitals had to have a 30 percent of their beds available so we wouldn't run into this problem again.

So this is working on multiple levels, and it's something that we're monitoring very closely.

ASSEMBLYMEMBER BYRNE: Okay, thank you.

Well, I would help that we can again keep this conversation going not just in the middle of an emergency or a pandemic as the way to increase access.

Often in the legislature we talk about insurance, but there's also, again, raising that ceiling, increasing access through other means.

Also, one quick question about ventilators.

You talked about everyone that needed a ventilator got one.

There was conversations about using bag-valve masks, about using BiPAP machines, about using splitters.

Were any of those technologies used?

COMM. HOWARD ZUCKER: The BiPAP machines were used, but part of it was, not because there wasn't a ventilator. It was because it was a therapy that was more beneficial to that patient at that time, to use it that way.

We did not need to do any manual ventilation with a bag and a valve, but we were ready, we were ready. And the same with the splitting, we were ready for that.

SENATOR RIVERA: Thank you, Commissioner.

Thank you, Assemblymember.

Now I'll recognize Senator Pam Helming for 3 minutes.

SENATOR HELMING: Thank you, Senator Rivera.

And thank you, Commissioner, Mr. Rhodes, and Dr. Malatras, for your testimony today.

I want to talk for a moment about our small rural hospitals.

As we all know, our small rural hospitals are absolutely critical for meeting the medical needs of people living outside of the large metropolitan areas.

These hospitals in our communities, they're also major employers, and they do so many other positive things for our communities.

Before the COVID-19 outbreak, many of these rural sole community providers, and, as Senator Rivera has already talked about, our safety-net acute-care facilities, they were facing significant financial challenges.

And as we all know, these hospitals, they've been operating on incredibly thin margins for the past several years.

Now with additional burdens associated with the last [indiscernible], due to the mandate to cancel elective surgeries, on top of all the investments that they had to make to prepare for the pandemic, these hospitals are experiencing significant financial challenges.

So, Commissioner, I was wondering if you could speak to the efforts being made on the part of the State to stabilize and save our rural hospitals.

I know you mentioned the $1 billion of

federal funds that had been distributed.

But, from what I'm hearing, that's not going to be enough to do the job.

These hospitals are looking that there may be a second surge, their elective surgeries may be canceled.

So if you can just speak to what's being done to help our rural community hospitals?

COMM. HOWARD ZUCKER: Sure.

So you know that we have incredible commitment to the rural hospitals, and we have an entire team in the department working on this exact issue, even before the pandemic, to make sure that the hospitals -- the needs of those hospitals are met.

This is a challenge, and I understand this is a complex issue.

And we will make sure that we do everything to protect, as best as we can, the hospitals in the areas that had the elective surgeries canceled, and, obviously, fortunately so, didn't end up with the challenges of a lot of COVID patients there.

But I recognize this was a hit to the hospitals at -- on a financial level, and we are looking at this in the bigger picture of rural

health.

So I hear your concerns, and we'll address it as we move forward.

SENATOR HELMING: Thank you.

I'm looking -- I look forward to more specific details.

COMM. HOWARD ZUCKER: Sure.

SENATOR HELMING: Also, I just want to comment, that when we talk about health disparities, I often hear of it in terms of, you know, we have problems in our Black and Brown communities.

We need to make improvements, and I 100 percent support that.

But I also feel that our rural communities need -- the issues there need to be addressed with the working poor.

We need to have equal access. We need access to tests.

I know there have been so many conversations about the PPE.

I am telling you that I have heard from hospitals, despite what you heard, and I've sent letters as late as mid-May, requesting PPE for these those hospitals, gowns, masks, and more, and it didn't happen.

It didn't happen.

COMM. HOWARD ZUCKER: And I hear you -- I know time's up.

I hear you about the health disparities, and it crosses many different areas.

I see the time.

SENATOR RIVERA: Thank you, Commissioner.

Assembly.

ASSEMBLYMEMBER MCDONALD: We will now hear from Assemblymember Ranker Brian Manktelow.

ASSEMBLYMEMBER MANKTELOW: Good morning.

Can you hear me?

ASSEMBLYMEMBER MCDONALD: Yes, we can.

ASSEMBLYMEMBER MANKTELOW: Perfect.

Commissioner, just a couple of questions in regards to ventilators.

At the start of the pandemic, when we first realized we had to have ventilators, how many ventilators did New York State have at that point?

COMM. HOWARD ZUCKER: We had -- I have to get you the exact number of the ventilators we had at that point. I have to look that one up. I don't have that right off the top of my head.

But I knew that we needed more.

ASSEMBLYMEMBER MANKTELOW: Can you

ballpark -- can you just ballpark it?

COMM. HOWARD ZUCKER: [Indiscernible] thousands of ventilators. And we had to -- you have to remember, some of the ventilators that we had in the state were already provided to the hospitals.

And so we needed to find out where -- where, and which hospitals, that there were ventilators from the State.

But also the hospitals, if you're asking the bigger question of, "how many ventilators?" when we started to look for ventilators, you start to find out that a hospital's ambulatory surgery center have ventilators. Every anesthesia machine is, basically, a ventilator; you have ventilators there. Office-space surgery practices sometimes have -- many times have ventilators.

So we needed to figure out how many there were out there, and that was part of the effort to get those numbers and to figure those out.

DR. JAMES MALATRAS: Early on, Assemblyman, the governor [inaudible] because it was a major concern of ours. But we thought the need would be upwards of 40,000 ventilators.

We started, I think, in the system, before we started working with folks, with about 2500 to

3,000 ventilators, early on.

ASSEMBLYMEMBER MANKTELOW: All right.

How many do we have right now -- do you know? -- on hand?

COMM. HOWARD ZUCKER: I can get you the exact number of how many we have on hand.

ASSEMBLYMEMBER MANKTELOW: The ones that we do have on hand, are they being stockpiled in case we have a second wave?

COMM. HOWARD ZUCKER: We do have hundreds of ventilators in the stockpile right now.

We also have -- are finding out which ones we have given out, and how to bring those back if they're no longer needed.

We also have ventilators that were out there, that now need to be brought back and serviced, because once they're used they need to be serviced.

There's a -- we have spoken with our federal partners about that as well.

So we are looking at all of these issues to make sure they're available.

We deployed 2600 ventilators during -- as I mentioned before, during the pandemic.

ASSEMBLYMEMBER MANKTELOW: All right. So the hospitals and facilities that gave up their

ventilators, they will be getting them back?

COMM. HOWARD ZUCKER: Oh, yes, right, they'll get [indiscernible cross-talking] --

DR. JAMES MALATRAS: To be clear, Assemblyman, every hospital that did give or loaned a ventilator have been given their ventilators back.

That is not in [indiscernible].

Our number of intubated patients are so low in the state of New York right now, those have all have been returned.

No hospital has given -- no hospital has any ventilators on loan right now.

ASSEMBLYMEMBER MANKTELOW: Oh, okay. Perfect.

And when -- I know we reached out to the federal government to get ventilators from the federal government.

How many did we get from them? Do you know?

COMM. HOWARD ZUCKER: So we received ventilators from -- we had 2,000 ventilators that I believe -- I have to check the exact number. I think it was several thousand ventilators.

But I will get you the exact number of how many came from the feds.

ASSEMBLYMEMBER MANKTELOW: Okay.

And did we -- did some of them that came, did we use some of those?

COMM. HOWARD ZUCKER: Ventilators were used, they went out into the hospitals and to the communities, yes.

ASSEMBLYMEMBER MANKTELOW: All right.

So were those ventilators -- those ventilators were definitely helpful, then, to our residents in New York, by getting them [indiscernible] --

COMM. HOWARD ZUCKER: All ventilators were helpful.

And as I mentioned it, ventilators need to come back to get serviced. And so they were brought back and sent back for service to the facilities -- to the [indiscernible cross-talking] --

ASSEMBLYMEMBER MANKTELOW: So, Commissioner, we're replacing and we're buying ventilators right now.

What are we paying for those ventilators today, compared to a year ago?

COMM. HOWARD ZUCKER: I have to look at those numbers.

ASSEMBLYMEMBER MANKTELOW: And I'm sure there's a spike in cost. There's going to have to

be.

And if it's astronomical and really out of line, is that a place where our attorney general could look into that for us?

COMM. HOWARD ZUCKER: Well, we need to look -- I mean, this is where it goes back to what I was saying before, that we need to be sure that we have enough supply.

And this was the whole purpose of making sure that we have enough PPE. This is why the governor said 90-day supply. This is why the governor said about a Surge & Flex, and about all the supplies that we need.

We need to be sure, that if something were to happen again in the autumn, or subsequent months after that, that we have what we need, and we do not repeat the exercise that we just went through in the spring.

And so that's why we're making sure we have all the supplies that we would want.

DR. JAMES MALATRAS: [Indiscernible], we hear you.

That's why we are entering into the multi-state consortium. We've been working on those things.

So I think the governor mentioned at some of our briefings, and so you heard, there were ventilators that cost at around ten to fifteen thousand dollars per ventilator.

And at the height of the crisis, largely because supply chain is from China, they were charging upwards of $70,000 per ventilator, not just for New York, but, virtually, every state that wanted it.

So, you're right, that's something, at the time, where we were dealing with an emergency crisis.

Moving forward, having a multi-state consortium working to build that stockpile now is really important so we can keep that at a lower cost.

And if there is price gouging, and other things, I'm sure the attorney general will be involved.

ASSEMBLYMEMBER MANKTELOW: So my last question, then:

You know, we --

SENATOR RIVERA: Very quickly, please, since your time has expired.

ASSEMBLYMEMBER MANKTELOW: All right. I'll

ask it later on.

I just keep hearing about the second wave.

I just want to know where -- where are we getting those numbers, or where is that thought coming from, that we're going have a second wave this fall?

That's all.

COMM. HOWARD ZUCKER: Well, can I answer that?

SENATOR RIVERA: Very quickly, very quickly, please.

COMM. HOWARD ZUCKER: Bottom line is, if you look across the country, you see these spikes in Florida, Arizona, California, and you just look at the nation.

The concern is that, not so much the mutated virus potential, these individuals coming back into New York.

That's why we do this unbelievable contact-tracing program, to make sure, whenever there's a case in the state, we jump on it and we make sure we address it immediately.

SENATOR RIVERA: Thank you, Commissioner.

Now we'll recognize Senator Jim Tedisco for 3 minutes.

SENATOR TEDISCO: Hello?

SENATOR RIVERA: Yep. Go ahead, sir.

SENATOR TEDISCO: Hi, Commissioner.

COMM. HOWARD ZUCKER: How are you?

SENATOR TEDISCO: Good. How are you?

Good.

I believe there was a requirement over the last five months of this crisis, that every hospital would interact on a daily basis by telephone, and report to the department of health, to someone there, about the situation in their hospitals.

And I presume, although we beat it back very good, this virus, that that probably continues, to understand the PPEs, what their need is, number of deaths, number of COVID patients.

Now, you suggest you have done a holistic investigation of the crisis in our health-care facilities, and had it peer-reviewed from the outside.

But it kind of defies logic to suggest that you can come to a conclusion without the real starting point, and that's the real number of individuals who died in nursing homes, or, went to a hospital, were sick, and died.

My question to you is: Wouldn't it be simple

just to have, in that discussion over the phone every day, or to call the hospitals, I believe there's -- how many? -- 365 hospitals in the state of New York, and to ask them, either on that call, or the ensuing call the next day or the day after, what's the report on how many individuals died from COVID that came from a nursing home into your hospital?

What would be the difficulty?

Because you've just done a holistic report, you've said. But you did the report, came to a conclusion that it was the staff that caused that wildfire, without even having the real number [indiscernible cross-talking] --

SENATOR RIVERA: Senator -- Senator --

SENATOR TEDISCO: -- [indiscernible cross-talking] --

SENATOR RIVERA: -- if I may interrupt --

SENATOR TEDISCO: -- [indiscernible cross-talking] --

SENATOR RIVERA: -- Senator, I'm sorry.

Could you please pause, pause a minute.

So, Senator, as we stated multiple times, we already had all this -- all this time that we were talking about nursing homes.

Please focus on hospitals.

SENATOR TEDISCO: Yeah.

SENATOR RIVERA: Un-pause.

SENATOR TEDISCO: Okay.

Yeah, on those hospitals, are those calls ensuing?

COMM. HOWARD ZUCKER: There are calls reg -- well, two parts.

There are calls regularly with the hospital leadership on many different issues.

We also have a HERDS survey that comes out, to find out information from the hospitals, over 150 data points of information that comes in.

We did this for 130 days, and it's continuing. That was -- and we continue to get this information.

As Senator Rivera mentioned, we have already spoken about the issues of the nursing homes.

And I mentioned that I need to look at the numbers and the data, and I'm happy to report back to the leadership when that's ready.

SENATOR TEDISCO: So you could ask them on a daily basis, any question from DOH that you wish to ask them, and they could give you an answer?

COMM. HOWARD ZUCKER: I think that, you know,

sometimes we don't feel like the answer is very simple to get it, yes or no. But a lot of these answers are not that simple, and you need to look at some of this data and to try to tease it out.

And that's why, you know, someone sends a piece of information in, doesn't mean that it's -- it hasn't been looked at in the bigger picture.

And that's what we need to do.

Sometimes things are double-counted, sometime things come from -- it's inaccurate, and we need to go through it.

And that's what we usually do, on all information.

SENATOR TEDISCO: Thank you.

SENATOR RIVERA: Thank you, Senator.

Assembly.

ASSEMBLYMEMBER MCDONALD: We will now move into Assemblymember Edward Braunstein for 3 minutes.

It's a rapid-fire round, guys, and gals.

ASSEMBLYMEMBER BRAUNSTEIN: Good morning, Commissioner.

During the daily briefings at the height of the crisis, I recall the governor mentioning working to coordinate cooperation between hospital systems.

As you said earlier, it's common for patients

to be transferred within a hospital system, but not between hospital systems.

Can you just talk about some of the challenges you faced with that?

And, what changes are in place for potential surge and flex should we see a second wave?

COMM. HOWARD ZUCKER: I think that there's a natural initial tendency to sort of feel, like, well you know, we have our system and we are comfortable within it.

But when the governor addressed all the hospital leadership, and there are many calls to speak with all of the leaderships of all the hospitals, and particularly the major ones downstate, or the major systems downstate, there was an absolute collegiality on the part of the leadership to say, we are in an unprecedented situation, and we need to work with everyone. And whatever you need, New York State government, we are here to help.

And they did.

And that is why our numbers are the way they are, and that is why the system -- the hospital system rose to the occasion and helped out.

Now, as you just mentioned, the ability to

move within a system was the first thing that people wanted to do, but we did move between systems. We did move across -- all across the affected areas.

And I think that that was attributed to the commitment of all the doctors, the nurses, the whole health-care system, and all the leadership downstate -- or, for all over, but that was where it was affected the most.

ASSEMBLYMEMBER BRAUNSTEIN: So should we face another potential second wave and encounter the situation again, are there concrete plans in place to facilitate those transfers, or is it just going to be, we're going to call everybody together and have like a voluntary system?

COMM. HOWARD ZUCKER: This is why the governor has put forth the whole Surge & Flex plans, and all the -- this is one part of the many pillars of how to move forward from where we are, and continue to sort of operationalize exactly what we learned and did during the first part of this pandemic, to be sure that we do not have to repeat what we did before, and to put it into place.

And that's what we're doing.

And the hospitals recognize that, and they're on board.

DR. JAMES MALATRAS: Assemblyman, this is mem -- this will be memorialized -- it is memorialized in the regulation that was just issued.

So all of those component pieces will be included, so you can better manage from the various hospitals systems.

And part of what went into that was the data analytics, so you knew exactly where the hospital capacity was of each hospital, so you could address that need.

So all of those things that happened during the crisis is now memorialized in the regulation that will be ready for the fall, or any other [indiscernible], if it not COVID-19, whatever other infectious disease or pandemic may arise.

ASSEMBLYMEMBER BRAUNSTEIN: Great.

Thank you.

SENATOR RIVERA: Thank you, Assemblymember.

Now recognize Senator Alessandra Biaggi for 3 minutes.

SENATOR BIAGGI: Thank you, Mr. Chair.

And good morning, everybody.

My questions are predominantly for Commissioner Zucker, and they relate to an area of District 34.

So, Mount Vernon is a majority -- minority city located in Westchester County, which I'm sure you already know.

In 2010, Mount Vernon, New York, had approximately 60,000 people living in it.

Today it's estimated to be 100,000, and we will have confirmation of that after census comes back.

Are you, Dr. Zucker, familiar with Montefiore's plans to close Mount Vernon Hospital?

COMM. HOWARD ZUCKER: I am -- I know that Montefiore has looked at many of the different hospitals.

I am not specifically aware of what their plans are regarding that hospital at this point in time.

SENATOR BIAGGI: So Mount Vernon -- Montefiore has plans to close Mount Vernon Hospital.

And during the pandemic, the hospital had been operating at what's being considered limited capacity, despite the fact that Mount Vernon has had the second-highest number of cases in Westchester.

18 nurses were laid off from their ICU unit during the pandemic, and Montefiore, most recently, reinstated them because of our outcry.

On March 17th, myself, as well as several of my other colleagues, including Senator Bailey, had sent a letter to Governor Cuomo, requesting that the capacity at the hospital be fully utilized, really, to ensure, not only that Mount Vernon residents could have access to the hospital, but also because what we were hearing from nurses, was that, because there was not room in Mount Vernon Hospital because certain floors were blocked off, that in the transit from Mount Vernon Hospital to other hospitals in The Bronx, patients died.

And so, you know, at that time, New York State, of course, was scrambling to expand hospital capacity, making sure everybody could get a bed.

But my question most directly is: Do you think it is appropriate for hospitals to be closing, especially in communities of color, and especially in communities with such great need, as Mount Vernon, in these areas that have been highest hit with COVID, and, historically have comorbidities that have increased the likelihood that someone will not only become very ill, but also die?

COMM. HOWARD ZUCKER: Well, I think I answered that question when Senator Rivera asked

me about the need to be -- the efforts --

SENATOR BIAGGI: But I'm specifically talking about Mount Vernon Hospital.

COMM. HOWARD ZUCKER: Well, I can't comment specifically on Mount Vernon without having more of the facts, and to talk to the system -- the Montefiore system.

So I'm not going to comment about that, nor --

SENATOR BIAGGI: [Indiscernible] that the hospital is in a city that has incredible need. It's in the middle of a pandemic, as you've said. And, this is a community that cannot continue to sustain a low level of standard of care, when, historically, communities of color have received low standards of care.

So will you, as the commissioner, take a stand, and take a comment, and take a position, on the closure of Mount Vernon Hospital?

COMM. HOWARD ZUCKER: As all of these hospital issues and closures do come through the department, they go to the public-health policy council, when asked any of these kinds of decisions need to be made.

And when it's brought to my attention, I will

clearly review it and make a decision, and work with them when it goes for a vote at the specific meeting of PHHPC meeting.

And, obviously, this pandemic has made people look at things in a new light.

SENATOR RIVERA: Thank you, Commissioner.

Thank you, Senator.

Assembly.

ASSEMBLYMEMBER MCDONALD: Assembly would be, Member Tom Abinanti, for 3 minutes.

ASSEMBLYMEMBER ABINATI: There you go.

Okay.

Good morning, gentlemen. Thank you for joining us.

Commissioner, you keep saying: I have to look at this, and I'll get back to you. I have to look at this, and I'll get back to you.

A week and a half go ago we asked you for information, similar to what was asked today, like, the source of admissions to the hospitals/where did they come from, and what were the outcomes?

When will you have looked at this information?

When will you give it to us?

And where do you suggest we discuss it?

COMM. HOWARD ZUCKER: So I think there's a couple things here.

As I've said multiple times, and I think it's worth repeating, we are in the middle of a pandemic.

We have spent the course of the past 10 days, and just so you know --

ASSEMBLYMEMBER ABINATI: And so you're suggesting that, when it's over, then we'll have this conversation.

So we'll have to wait maybe six months before you tell us the source of the admissions?

COMM. HOWARD ZUCKER: No, Assemblyman --

ASSEMBLYMEMBER ABINATI: [Indiscernible] you just have to look at it.

COMM. HOWARD ZUCKER: Assemblyman, there was an ask about this staffing study, and I said I would have it to you on Friday, and I am reviewing it.

But I think it's worth raising the fact that, in the course of the past 10 days, the department has been working, literally, into the middle of the night, and I can tell you that, on some of the other issues that have been raised.

There's an issue [indiscernible cross-talking] --

ASSEMBLYMEMBER ABINATI: Commissioner, you

have the source of the admissions. It's simple numbers. All you have to do is release them.

When and where are we going to get those numbers?

I want to know how many came from nursing homes.

I want to know how many came from group homes.

I want to know how many came from the different congregate care?

COMM. HOWARD ZUCKER: Assemblyman, I understand -- I understand that the numbers are what you want. And I understand that.

But I also know that you want to be sure that there is someone who has looked, and be sure that they are accurate, and that there's no double-counting.

And that's what I'm going to do.

But [indiscernible cross-talking] --

ASSEMBLYMEMBER ABINATI: [Indiscernible cross-talking], but you don't have an answer.

I've only got a minute and a half left.

The visitation policy, has that changed?

Can you now visit hospitals as before the pandemic?

COMM. HOWARD ZUCKER: There are 207 hospitals that have provided visitation policies to us. There's over 120, I believe, that have already opened up. That number may even be higher.

We want to be sure --

ASSEMBLYMEMBER ABINATI: What I'm concerned about -- all right, Commissioner, what I'm concerned about is, during the height of the pandemic, you had non-verbal people, kids with disabilities, who were dependent on their parents and their caregivers at their institutions, at their homes, at their schools.

And they were brought into the hospitals, and the people upon whom they were dependent could not come in and translate for them what their needs were.

That's true, isn't it?

COMM. HOWARD ZUCKER: I understand, actually, all the hospitals have visitation now.

I just was thinking about this for a second.

All the hospitals have visitation --

ASSEMBLYMEMBER ABINATI: But in the future, will you work out a plan, please, so that we don't end up with the trauma being worse than the situation that people -- you're worried about?

COMM. HOWARD ZUCKER: I understand that, and I recognize that, and believe me, as a pediatrician, I am well aware of some of the challenges that those who have -- who have disabilities have, and the concerns.

So I recognize that.

But I'm balancing that with the risk of infections --

ASSEMBLYMEMBER ABINATI: The last question --

COMM. HOWARD ZUCKER: -- and the risk to those individuals --

ASSEMBLYMEMBER ABINATI: -- How many people --

SENATOR RIVERA: Actually, your time has expired --

ASSEMBLYMEMBER ABINATI: -- basically, what we're saying is --

SENATOR RIVERA: -- your time has expired, Assemblymember.

ASSEMBLYMEMBER ABINATI: -- the nurse, whose kid's in the hospital, she --

SENATOR RIVERA: Assemblymember, your time has expired.

Apologies.

COMM. HOWARD ZUCKER: I just -- Senator, can

I just mention that, the developmentally-disabled community, they are allowed to have a support person there.

So the expanded visitation is another story.

But there is the ability to have a support person there at this point.

SENATOR RIVERA: There are currently no members of the Senate set up to ask questions.

Back to the Assembly.

ASSEMBLYMEMBER MCDONALD: Member Linda Rosenthal, 3 minutes.

ASSEMBLYMEMBER ROSENTHAL: Okay.

Hi.

Hi, Commissioner, and thank you for being here.

As the chair of the Assembly Committee on Alcoholism and Drug Abuse, I was told by different individuals that hospitals in their area had temporarily closed the hospital inpatient substance-use disorder treatment programs, and were turning individuals away who came in seeking treatment.

The abrupt changes to normal treatment regimens from -- because of COVID, combined with the day-to-day interruptions that all of us are facing,

have placed many struggling with addiction at a much greater risk of overdose, and making easy access to treatment even more critical right now.

As you know, withdrawal is a painful process, but, if left untreated, it could also be life-threatening. And there's often a very small window of opportunity for an individual to enter a treatment program. When they are turned away, it can have disastrous consequences.

So I've been trying to get this information from different agencies, and I have been unsuccessful, which is why I'm asking you right now:

How many hospitals around the state temporarily closed their inpatient treatment programs as a result of the COVID-19 pandemic?

And what steps were taken to ensure that those who could not begin treatment or care at those hospitals had referrals to other programs?

And were those patients tracked, and do we know if they received treatment at other programs?

And, going forward, how will the department ensure that there's availability of substance-use disorder treatment during emergencies like this that may occur in the future?

COMM. HOWARD ZUCKER: So, a couple things.

This is primarily a question for OASAS, because [indiscernible cross-talking] --

ASSEMBLYMEMBER ROSENTHAL: No, no, no.

Let me interrupt.

I asked OASAS and DOH, both, on the phone, and they each did this (indication). And that's why I'm going to you.

COMM. HOWARD ZUCKER: All right, so Assemblywoman, what I will do -- I can't give you the number on this.

But what I will do is, I will find out exactly what -- I will work with OASAS on this.

Some hospitals have developed some inpatient detox programs. It's about 100 of those hospitals. I can't give you the exact names of which ones they are. But that's the amount that are out there right now.

I can sit down and talk to OASAS about that and get a little bit more detail.

No one -- though, I can tell you that no one has gone without services, that I'm aware of.

I'm sure you've heard stories, but I am not aware of any.

But if there are specific cases, we can sit down and talk about that, and I will try to figure

out how to address it.

ASSEMBLYMEMBER ROSENTHAL: Okay.

I mean --

COMM. HOWARD ZUCKER: And if I have to go back to [indiscernible cross-talking] --

ASSEMBLYMEMBER ROSENTHAL: I mean -- okay.

Thank you.

We know that because of all the withholding, that substance-use programs across the state have been severely damaged. And I'm very concerned about that.

And I know Co-Chair Rivera is as well. I see him nodding.

But hospitals did repurpose rooms, and I understand that they needed everything.

SENATOR RIVERA: Your time's ups.

ASSEMBLYMEMBER ROSENTHAL: But where did they go?

Okay.

Thank you.

ASSEMBLYMEMBER BYRNE: Point of order, Chairpersons, I just noticed that we have limited time here with the Commissioner, and we haven't been rotating Majority and Minority members for testimony.

Several of the Assembly Minority Conference have had their hand raised for -- from the very beginning.

They were not able to answer [sic] questions of the commissioner at previous hearings.

And I would appreciate it if we could get back on track and alternate those speakers, please.

ASSEMBLYMEMBER MCDONALD: Okay.

Anything in the Senate?

SENATOR RIVERA: No, sir.

We will go with Missy Miller.

ASSEMBLYMEMBER MILLER: Hi. Thank you so much.

Good morning, everybody.

I just want to know, and I apologize if I missed it before, but, just back to PPE:

There seemed to be a terrible disconnect between what hospital administrators, what hospitals were saying they had, and what staff, doctors, nurses, on the front lines, treating these patients, were actually able to get.

I know -- you know, with an underlying condition, like Oliver, he, unfortunately, had several admissions during this period.

And each time we were there, the nurses, and

even the doctors, were saying that they had to reuse PPE. They didn't have enough masks.

The regulations were different each admission. They didn't -- they were very confused. They didn't know whether they were supposed to be masking, shielding, full garb.

You know, so there was a lot of confusion, and mostly disconnect, between the people/the staff actually working, the nursing supervisors who were providing and giving out, and, you know, telling them what the actual to-date regulation was for PPE, and what the hospital administrators were actually saying.

So, has that been corrected?

Is that something that, moving forward, won't happen anymore?

Is there an oversight to that?

COMM. HOWARD ZUCKER: So the hospitals need to report to the state how much PPE they had on hand. This was a daily part of our HERDS survey. And, in addition, they had to tell us what their burn rate was.

If there was a need that was not being met, we were available to provide that.

They went to the County, went from the County

to the hospital, but we were working on those issues.

That's one part of the answer.

The other part is that, when you asked about the face shields versus masks, you have to remember that, as this was evolving, we were learning more about this.

This is one of the challenges of, whether it's a pandemic or just a new virus, is we did not know all the information, not because we didn't know, no one knew.

And as [indiscernible cross-talking] --

ASSEMBLYMEMBER MILLER: Of course, right, it was unknown.

But, there was that disconnect between hospitals reporting to the State or OEM, what they had, saying they had.

I was, myself, calling hospitals, saying: Do you have PPE? Are you in need?

No, no, no.

And then we would show up, and, boom, the nurses are saying, uh, this is ridiculous. I have to go wash this off. I have to reuse this.

Why was that disconnect there, from what they're reporting, that their burning through?

Was it because they were so nervous of running out, that they weren't supplying their front-line workers with what they actually needed?

COMM. HOWARD ZUCKER: I'm happy to talk with the hospitals --

ASSEMBLYMEMBER MILLER: I reported it several times on the governor's update calls.

I said -- you know, after each admission, I'd say, this is crazy. Why is there this disconnect?

And so they were aware of this disconnect.

COMM. HOWARD ZUCKER: Well, the State did give out 24 million pieces of PPE.

And if there was a concern, we did respond accordingly.

I hear what you're saying about what you saw with Oliver on the front line in the hospital. And I'm happy to get back to you and talk about the specifics.

But I can tell you that, going forward, this is part of why the governor has put in place the 90-day amount of PPE [indiscernible cross-talking] --

SENATOR RIVERA: Thank you, Commissioner.

COMM. HOWARD ZUCKER: -- so, and that's why we have them.

SENATOR RIVERA: Thank you, Commissioner.

Thank you, Assemblymember.

ASSEMBLYMEMBER MCDONALD: Still the Assembly, Member Ellen Jaffee.

ASSEMBLYMEMBER JAFFEE: Thank you.

Thank you, Commissioner.

What I wanted to get a sense of was the -- how will our youth have been impacted by COVID?

And are those numbers --

SENATOR RIVERA: Assemblymember, if could you turn on your camera, please?

ASSEMBLYMEMBER JAFFEE: I'm sorry.

I'm sorry. I thought --

SENATOR RIVERA: Thank you.

ASSEMBLYMEMBER JAFFEE: Thank you.

In terms of the -- I was just wondering, the number of our youth that have been impacted by COVID?

And are those numbers increasing?

Have they, you know, control -- been under control?

And the ages of our youth that are -- really have, you know, suffered through this?

COMM. HOWARD ZUCKER: Sure.

So, fortunately, you know, this virus has not

impacted the younger population the way other viruses actually have.

The percentage of kids who have been affected is down in the 1 percent range, or -- or, in some places, even lower.

We monitor this very closely.

I have to tell you, sort of as a pediatrician, I am sort of trying to figure out why?

And there's a lot of thoughts about that, and there's a lot of scientists out there looking at this.

Perhaps, initially, there may be some [indiscernible] activity from the immunizations they get, which would be beneficial, and that would help.

There's maybe other reasons as well, just the immune system, of how a kid's immune system is versus adults.

But one challenge we have seen, and New York was the first state to really jump on this, was the issue of the multisystem inflammatory syndrome in children.

We have seen 245 cases of that in the state. And we have, unfortunately, lost two children to that. This was an infection -- or, inflammation, I should say, that occurred about four weeks after

they got sick.

We addressed this. We are monitoring it.

We were the first state to really look at this and monitor this.

I have spoken to my fellow commissioners around the country about this. Many states don't even report this.

We look at many different aspects of pediatric care, including the psychosocial impacts of children who are sort of living through a pandemic, and may not be able to sort of grapple with the impact of this, and understand what is happening.

So we are addressing that as well.

But -- and we monitor what happens to all the kids, and whether they have other medical conditions.

The vast majority of the children who have died, and it's only been a handful, have had other medical conditions as well.

And I'd be happy -- I know your time is short, so I'd be happy to share more with you afterwards.

ASSEMBLYMEMBER JAFFEE: Thank you.

Just one of the reasons I'm asking that

question is, because we are moving forward -- I'm a former teacher -- moving forward to the possibility of opening our schools at this point.

And there has been very real concern raised about the impact of the COVID on our youth.

And I was wondering the numbers at this particular point, of whether it is something of a very real concern.

Are they having the -- are they -- is it under control in terms of, the youth are not falling into that as much, the numbers are not as great as --

SENATOR RIVERA: Thank you, Assemblymember.

ASSEMBLYMEMBER JAFFEE: I'm finished.

SENATOR RIVERA: Your time has expired.

ASSEMBLYMEMBER MCDONALD: Next up is Assemblymember Garbarino.

Assemblymember Garbarino?

ASSEMBLYMEMBER GARBARINO: Thank you, Chairman.

Dr. Zucker, thank you very much.

I also -- I just want to say, your office was very helpful during the uptick.

A lot of the calls that we had, dealing with your staff, they were very helpful in helping some

of my constituents' problems.

So I do want to say thank you, because I know you're probably getting called from every member of the legislature.

But I specifically want to ask questions about what your thoughts, being the head of the DOH, was to the federal support that we received during the peak?

You know, the field hospitals, the hospital ship, the ventilators, the PPE, did you -- was it enough, did we get enough, from the federal government that we needed?

COMM. HOWARD ZUCKER: I think that there are multiple parts to the answer -- parts of an answer -- the answer has multiple parts, I'll put it that way.

The first part is about Javits and "Comfort."

So we worked with the federal government to get Javits and "Comfort" in place. The governor asked that these be converted to COVID-positive facilities because, initially, they weren't not.

That provided the ability to care for 1,095 patients at Javits, and 282 at the "Comfort."

So that was helpful for us, to be able to work with FEMA and others on that issue.

There have been challenges in sort of the last of national leadership and coordination on this issue.

I have worked and spoken with everyone, from the CDC director, to FDA commissioner, and to members of the HHS leadership, about things when we needed some dialysis machines. They were able to provide it.

But I think the issue is about leadership at a federal level.

And if that was there up front, I think things would have been different.

But, absent, you know, the federal leadership, we, as a state, have really led the charge. And you can see this with the numbers that we now have, less than 1 percent even positive in the state.

ASSEMBLYMEMBER GARBARINO: Well -- now, are you -- with the possibility of a second wave, are you currently in discussions with HHS or the Army Corps or FEMA or CDC about what to do, what we need, from the federal government?

Has that -- have -- are [indiscernible]?

COMM. HOWARD ZUCKER: So I think the way we broke down Javits was, so that we can get this up

and operational again within 72 hours.

That was why the way it's packaged, and ready to move forward.

We have conversations with -- I've had conversations with HHS, if there are certain needs. There were dialysis machines that were needed, and they were able to provide those to us.

This is a constant dialogue.

And the same with issues with the CDC.

And, you know, there are always challenges, and there are always things that we -- we would like others to do and help us better.

But I think -- I think those conversations between, you know, public health officials on a regular basis.

We're talking with HHS about the Strategic National Stockpile as well, because that's where there's supplies.

I was a little surprised, you know, at what wasn't there. But, you know, who expected, you know, some of the challenges that we faced.

But we met those challenges at a state level.

SENATOR RIVERA: Thank you, Assemblymember.

Thank you, Commissioner.

Next?

You're muted, Assemblymember.

ASSEMBLYMEMBER MCDONALD: Next up is Aileen Gunther.

SENATOR RIVERA: Recognized for...?

ASSEMBLYMEMBER MCDONALD: 3 minutes.

SENATOR RIVERA: There you go.

ASSEMBLYMEMBER GUNTHER: Am I there?

Hi.

Hi, everybody.

So I'm going to be quick because I only have 3 minutes.

So I want to quote from a guidance issued by the DOH on March 28th.

"Entities may allow health-care personnel with confirmed or suspected COVID-19, whether health-care providers or other facility staff, to work if all of the following conditions are met."

The first condition on the list is: The furloughing of such HCP would result in staff shortages that would adversely impact operation.

Second is, that: They isolate for seven days and have no symptoms for 72 hours.

This is despite the fact that we know asymptomatic people can spread COVID.

I would note, there is no requirement for the

HCP to show negative results.

DOH even goes on to say, that: The HCP experiencing mild symptoms can go back to work as long as they wear a face mask.

So we have health-care personnel who are potentially COVID-positive going to the hospitals.

This is despite all the knowledge we had at that point.

This guidance was not issued back in February when we knew very little about the virus.

This was issued late March, when already -- when already knew that asymptomatic people could carry COVID.

COMM. HOWARD ZUCKER: So there's a couple --

ASSEMBLYMEMBER GUNTHER: I just want to finish, I want to finish, because this is important to me.

So -- so, as was stated, Wadsworth had developed at that point, by late February.

Why wouldn't DOH require a negative test result from a health-care personnel who had tested positive?

If it is truly due to staffing shortages, and I'm going to repeat, staffing shortages, what is the State doing to ensure that all health-care

facilities, due to what you say might be a second wave, have enough personnel to not have to send staff who are sick back to work?

Do you believe statewide staffing ratios are needed to ensure this doesn't happen?

And I will say, as a registered nurse, I also was the infectious disease nurse in the hospital, president of APIC in the Mid-Hudson region. And we know about transmission.

And I think that I have begged and begged for safe staffing.

And, you know what?

There are -- it would be so fiscally responsible to do it, because we're paying plenty of overtime at this point.

And for the safety of our patients, whether it be long-term care or acute care, you know what? Nurses are the backbone of health care.

We really get little to no -- we have been picketing on the streets. We have been crying for it for year after year after year.

After this COVID pandemic, isn't it time to reconsider safe staffing, to be able to go into these acute-care facilities and long-term care facilities?

I'm emotionally distressed by the lack, or the inactivity, of the governor, and of all [indiscernible cross-talking] --

SENATOR RIVERA: Thank you, Assemblymember. Your time has expired now.

COMM. HOWARD ZUCKER: So let me -- let unpack that -- the question, because of some key points.

Number one --

Yeah, I'll do it quickly.

-- because there's a fact that's inaccurate there.

The asymptomatic spread was not as known back then. In fact, it was June 9th that the WHO put out a statement that asymptomatic spread can occur.

I'm just sharing with you the facts on this.

And these are CDC guidelines.

The previous -- your esteemed colleague, the previous speaker, mentioned about working with the federal government.

So I worked with the CDC on many of these things, and we took the guidance from the CDC regarding, I don't want to repeat some of the parts that you mentioned, about those [indiscernible cross-talking] --

SENATOR RIVERA: We only have -- we only have

a few more members to [indiscernible] questions, so let me go ahead and do that.

ASSEMBLYMEMBER MCDONALD: We have two members left, and that'll be it for Dr. Zucker.

And we'll go to John Salka.

SENATOR RIVERA: Recognized for...?

ASSEMBLYMEMBER MCDONALD: 3 minutes.

SENATOR RIVERA: Thank you.

ASSEMBLYMEMBER MCDONALD: 3 minutes.

ASSEMBLYMEMBER SALKA: Yeah, first of all, thank you, Commissioner, for being here today.

And this is a bit of a clinical question.

We understand that it's -- it can be considered kind of any port in storm right now with the ventilators that we have available.

But as I have been a respiratory therapist for 30 years, I understand that treating the pulmonary implications of the COVID virus is an extremely complicated clinical picture.

Are you confident that the equipment that we have available right now will give long-term clinical outcomes that will be something that the patient would actually get the best care they could?

I know that they -- when they were talking about splitting ventilators, that sent a chill up my

spine.

So my question is: In fact, are you satisfied with the best clinical guidelines that are being offered right now in the care of these patients, and confident that we won't have a major number of people that will be suffering from long-term consequences of inappropriate care -- what could possibly be inappropriate care?

COMM. HOWARD ZUCKER: So, first, I don't think it's inappropriate care because, at that point in time, you have the clinical information. And you have to make a decision based on that clinical information you have.

I have lived my life, prior to being in government, making those kind of decisions.

So I think that we provide -- when someone has respiratory failure, provide ventilatory support.

As we learn more about this virus, we learn different ways with -- of managing these respiratory [indiscernible]. If there are other ways of managing respiratory failure, you can address it.

And we learned that, and that's when we learned how to care for more and more COVID patients.

Long term, I can't predict the future.

We talk about the respiratory issues, but we don't know whether the other impact -- other systems that may be impacted by this virus.

This was an article in the cardiology journals the other day about the cardiac implications from coronavirus.

So we are looking; the scientists are looking, the doctors are looking, the researchers are looking, and we will figure this out.

But it is too early to make a prediction about what -- or, to make predictions. But it's too early give you an answer about what will be some of the potential long-term effects.

But I do not believe that this was inappropriate care.

It was the care that needed to be provided at that moment in time, based on the information we had.

It goes back to [indiscernible], which is, basically, you get more information; and then we have more information, you make a different decision.

And that's exactly what we were doing.

ASSEMBLYMEMBER SALKA: No, I understand,

we're all on a learning curve at this point right now.

I talked to fellow therapists and clinicians, and it was kind of, in some respects, a hit-and-miss thing on how we treated these patients.

But I just want to make sure that, when we look at a ventilator, and we spend fifteen or twenty thousand dollars on that ventilator, that it's a piece of equipment that is properly able to manage that complicated clinical picture.

COMM. HOWARD ZUCKER: May I add --

ASSEMBLYMEMBER SALKA: I want to [indiscernible].

COMM. HOWARD ZUCKER: May I add just one thing, is that, we talk about this regarding this pandemic and COVID-19.

But as others in the legislature mentioned, what about a different kind of illness, or a different virus, or a different bacteria?

So we want to be prepared, if a ventilator supportive -- can support them during their acute phase of their illness.

So we need to look at the big picture.

ASSEMBLYMEMBER SALKA: Thank you, [indiscernible].

SENATOR RIVERA: Thank you, Assemblymember.

ASSEMBLYMEMBER MCDONALD: Last, but not least, our colleague Jake Ashby.

SENATOR RIVERA: Recognized for 3 minutes.

ASSEMBLYMEMBER ASHBY: Thank you, Mr. Chairman.

Commissioner Zucker, was your department denied any equipment or resources requested by the federal government?

And, was the White House helpful with what it did deliver?

COMM. HOWARD ZUCKER: So this goes back to what we were talking about before, regarding supplies and asks for equipment that -- ventilators or dialysis machines.

But when we asked for the Javits Center and for the "Comfort," we worked with them to get that set up.

I'm not sure exactly your -- the specific questions.

When I spoke with CDC about certain things, we got information.

But this is a much more complex process than just a yes-or-no answer.

ASSEMBLYMEMBER ASHBY: Were you ever

denied -- was your department ever denied resources by the federal government?

OFF-CAMERA SPEAKER: We had asked for more ventilators at one point.

COMM. HOWARD ZUCKER: Ventilators, yes.

ASSEMBLYMEMBER ASHBY: Okay?

OFF-CAMERA SPEAKER: But [indiscernible] the federal government only had 10,000. They did not give us our full request.

ASSEMBLYMEMBER ASHBY: Anything else?

OFF-CAMERA SPEAKER: That is the one that [indiscernible].

OFF-CAMERA SPEAKER: That's the one.

ASSEMBLYMEMBER ASHBY: Okay.

So other than the ventilators, resources that the federal government provided that you requested, they were helpful?

COMM. HOWARD ZUCKER: I guess you could bring up the issue that, testing, because it ended up being that our Wadsworth lab created the test.

And when we said we needed more testing, it wasn't there.

So that is a problem.

And if we had that, and if we had more tests, we probably would have figured this -- you know,

what was going on a little bit sooner.

So I think that, you know, when someone said, "well, what would you have liked from the government?" I would have liked more testing from them, and be able to go forward.

ASSEMBLYMEMBER ASHBY: Okay.

Yeah, Wadsworth is in my district as well, so I'm fully aware of that.

But with the ventilators, we didn't end up using all of the ventilators as well, though; correct?

COMM. HOWARD ZUCKER: The ventilators that the federal government gave us went out to the hospitals, yes.

ASSEMBLYMEMBER ASHBY: Okay.

Thank you.

DR. JAMES MALATRAS: Just one more point, on the larger question, Assemblyman, of federal need, which would be, I think many of the questions were raised by many of your colleagues on rural health-care facilities, urban health-care facilities, other things.

Federal funding for state and local government hospitals and education are critically important as we go forward in the latest -- in the

next funding round.

ASSEMBLYMEMBER ASHBY: Appreciate it.

SENATOR RIVERA: All righty.

Thank you, Assemblymember.

Thank you, Commissioner.

Thank you, Mr. Malatras and Mr. Rhodes.

That concludes your section.

We will now move on to -- oh, one thing that I wanted to say on the record for every member, both for -- regarding the first two hearings on nursing homes, and this one as well, if there are questions that you still feel that the commissioner or the administration should answer, please get those questions to both the chairperson -- to Chairman Gottfried or myself in the next few days, as we put a document together to get to the administration.

Thank you for that.

We will move on to Panel 2.

That will be Carlina Rivera --

Not my cousin. I know you all were thinking it.

-- chair of the Committee on Hospitals from the New York City Council.

ASSEMBLYMEMBER GOTTFRIED: Okay.

Thank you.

And welcome, Councilmember.

In addition to chairing the Council Committee on Hospitals, your district also overlaps a little bit with mine.

So, do you swear or affirm that the testimony you're about to give is true?

CARLINA RIVERA: I do.

ASSEMBLYMEMBER GOTTFRIED: Okay.

CARLINA RIVERA: Thank you, and good afternoon.

Hello, my name is Carlina Rivera.

I am a member of the New York City Council, and I am chair of the council's Committee on Hospitals.

I want to thank the committee chairs for giving me the opportunity to provide testimony at today's hearing.

And, of course, to all of your colleagues for their very thoughtful and passionate questions to the previous panelists, our leaders in the state department.

As Hospitals' chair, I saw just as all you did, the disaster of the COVID-19 pandemic's worst days unfold right before my eyes in communities

across our state.

My team and I spent late nights and countless hour on the phone this spring with hospital administrators, front-line workers, and advocates.

And while I'm thankful that our state's new COVID case counts are at record lows, thanks to the hard work of so many health-care workers and everyday New Yorkers, I'm also thankful that we are holding a state hearing today to examine the one hard truth we still have not solved.

Simply put, our initial massive failure in responding to the pandemic, which resulted in a COVID-19 death rate that no other state has matched to this date, could have been lessened if the unequal systems that have been in our hospitals for decades were addressed through legislative and regulatory changes at the state level.

There is no doubt that, due to lack of support from the federal government and the Trump administration, New York was forced to go it alone without the federal resources one would normally expect during a pandemic of this magnitude.

And there were certainly challenges none of us could have foreseen, but these basic inequities in public and private hospital financing, and

workplace protections and resources, and in where patients can afford to receive care, played an outsized role in preventing thousands of patient deaths in New York State hospitals.

I know you have already heard from and questioned our state health commissioner, Dr. Howard Zucker, which I was watching his testimony before hearing my own.

I know Dr. Zucker defended the response from the State and hospitals, and I respect his efforts during a rapidly evolving crisis.

I also know he left many questions unanswered, and only committed to explore some ideas on how his agency could better prepare for a second wave.

But I prefer to focus in my testimony on what you, our state legislators, can potentially do to help us compel the State and hospitals to act now to prevent a future COVID-19 surge, and permanently address the inequities in our health-care system.

I just want to make sure -- all right.

I'm going to try to breeze through this as quick as I can, considering the timing.

For the remainder, I just want to note a couple of legislative actions that I think are

certainly possible, and that I know that you both respective chairs have explored in the past.

So, mandate resource pooling and fair distribution of PPE and medical supplies across all hospitals and medical facilities, with contracting done through the State or another centralized entity that can maximize purchasing power.

Institute a more concrete and transparent systemwide emergency response plan, not just in name only, with clear and public organizational frameworks, chains of command outlining roles between the state, local municipalities, hospitals, and hospital associations, and more express directives on how to handle COVID-19 patent care during the surge with limited resources.

Ensure any plan also includes requirements for and streamlining of rules for proactive out-of-system patient transfers so that public hospitals or those that are not part of a major network are not overwhelmed at any point during a second surge.

Ensure that visitation and patient advocacy policies reflect not only the safety of front-line workers, but also the need for mental support and a voice for patients and families.

Require all hospitals and medical facilities to proactively work with contract tracing teams by sharing an equal load in testing responsibilities, as well as requiring testing for anyone who visits a hospital or outpatient facility for any level of care or for a long period of time.

Temporarily halt the closure of any hospital facilities that were slated to occur through the certificate-of-need process.

Require more stringent reporting on access to hospital emergency rooms and beds for under- or uninsured patients.

Require hospitals to provide data and reporting on their surge capacity, and how it is being maintained, both structurally and in terms of workforce.

Ensure all COVID-19 data is transparent and accurately measures impacts to the hardest-hit communities.

Mandate that hospitals provide real mental-health and supportive resources to front-line workers beyond this one-size-fits-all approach.

And pass new revenue generators, such as the pied-á-terre tax, a wealth tax, and the closure of corporate loopholes, to restore Medicaid cuts passed

in the fiscal year 2021 state budget, starting with cuts that most acutely affect enhanced safety-net hospitals.

And in the long term, the State must pass legislation to restore the state's community planning process for hospitals and health-care facilities that existed through the 1980s, and integrate it into a more modernized certificate-of-need process that is more patient representation and public input, as well as a health equity impact assessment.

Pass strong --

SENATOR RIVERA: Thank you, Councilmember.

You have -- if you have, like, one last thought?

CARLINA RIVERA: Sure.

I mean, we've mentioned:

State staffing.

Expanding on reforms to the way Medicaid reimbursement and indigent-care funds are distributed to safety-net hospitals.

Mandate nation-leading training and instruction on implicit bias.

And, of course, I guess I'll end with, passing the New York Health Act --

SENATOR RIVERA: Got you.

CARLINA RIVERA: -- which I fully, fully support.

SENATOR RIVERA: Thank you.

CARLINA RIVERA: We all know that it has a lot to do with systemic racism.

And I want you all to know that, while my committee does have oversight authority to question and examine New York City's public and voluntary hospital systems --

SENATOR RIVERA: Thank you, Councilmember.

CARLINA RIVERA: -- you all have the ultimate authority.

SENATOR RIVERA: We have to wrap up because we'll move to questions --

CARLINA RIVERA: Sure.

SENATOR RIVERA: -- because we have a long hearing.

First, we'll be led off by the Assembly.

ASSEMBLYMEMBER MCDONALD: And that will be led off by Chair Gottfried.

ASSEMBLYMEMBER GOTTFRIED: Thank you.

I guess Senator Rivera forgot the rule that we give extra time to anyone who says they favor the New York Health Act.

But I have a question.

CARLINA RIVERA: I'm very in favor of it.

ASSEMBLYMEMBER GOTTFRIED: Councilmember, you talked about the need for rules on transfers of patients from one hospital system to another, essentially, to avoid dumping of patients from one system to another.

Is that something that we just need to be mindful might happen and we want to avoid it, or do you think that was happening during the peak months?

CARLINA RIVERA: I think in the immediate, patient transfers and resource pooling was probably one of the biggest failures during the pandemic.

I think patients were most often transferred only when they were in emergency situations and the hospital had reached critical capacity.

I think Dr. Zucker is absolutely correct in saying that patient transfers in these situations can be very, very dangerous.

But where we could have done better is with ambulances, for example, which often did not get diverted to less-busy hospitals unless a hospital hit max capacity.

And this was standard operating procedure prior to the pandemic, and usually only affected our

busiest public hospitals, such as Elmhurst.

And I think, secondly, hospitals could have been more active in, certainly, managing patient populations and transferring lower-risk patients sooner.

However, hospitals are often not ready or willing to do this beyond their own networks.

And -- because, as I heard from administrators and advocates, they had concerns about how insurance and medical records would be handled in these cases.

And I think that what we saw during the pandemic, which I have said many, many times, is that there was supposed to be this one network of everyone working together. And I certainly think that was more in theory than in practice.

And, you know, this just meant that patients were often rushed to other hospitals when they were already critically sick, resulting in many unnecessary deaths during transfers, or, in cramped conditions in overstretched hospitals.

And I think, in terms of resource pooling, we all know the problem here.

Supply chain management is best solved through consolidation.

And that simply did not happen at the scale that it should have. And hospitals were desperate, they were scrambling, to get the best supplies that they could have gotten for their workers and patients.

And the State should have stepped in, probably fully taken over supply chain and contracting, and then removed that additional work, since they were already overwhelmed.

ASSEMBLYMEMBER GOTTFRIED: Thank you.

SENATOR RIVERA: I'll recognize myself for 5 minutes.

You know, I thought that Dick was going to say that we give everybody whose last name is Rivera a couple -- a little bit more time.

But -- so thank you for joining us, Councilmember.

I wanted to focus a little bit on the disconnect that exists. And I want, from your perspective, as you've been looking at it, the disconnect that might have existed between the State and the City, in how -- because we know most hospitals are in the city of New York. Certainly, most public hospitals are in the city of New York.

And we have been consistently talking about

some of the disconnect that has existed in many policy areas, not just in health care, between the State's -- the State and the City's administration.

And, unfortunately, sometimes the people get stuck in the middle are the folks that are hurt.

Those are the folks that I want to talk about.

So if you could talk a little bit about, from your perspective, as you looked at hospitals in the city, what about that disconnect that might have existed between the State's administration and guidance, and the City's efforts, and how that clash might have led to us not functioning as effective as possible.

CARLINA RIVERA: That's a great question.

I mean, you know, we always -- hindsight is always 20/20 -- right? -- on how we could have worked together a lot better.

First, I just want to say that I don't think -- I don't think any hospitals were particularly at fault. I think every hospital did their best to handle the crisis.

I think the issues of inequity here that accelerated this crisis are much more systemic.

And while the state department of health did

heroic work to stand up to a massive response, I do think that they're at fault for not being as transparent about their response during the first wave, and even today at this hearing.

I also think that we could put blame on -- we should be putting blame on a number of interest groups that have worked to block legislation to address decades of hospital deregulation.

Certainly, we all know that the Greater New York Hospital Association has a very close relationship with the State. And, in fact, they played a very important role in the active coordination of care.

I think we'd all be well-served by taking a careful look at that relationship, and how they can, I guess, be more transparent and better support the public system.

In terms of who bore the brunt, I mean, we all know that it was communities of color that bore the brunt of these deaths.

It's because many New York immigrants, New Yorkers of color, a public hospital emergency room is, unfortunately, their only option for primary care or treatment.

And that just isn't a smart way to provide

care, from a safety perspective, from a financial perspective, and even from a care perspective.

So as private hospitals have retreated from communities of color, or consolidated into large networks, for many New Yorkers there isn't even an option nearby to receive treatment, and that's before you even get into insurance.

So in terms of how they're working together, you know, what I've witnessed, and, again, in my capacity as chair of Hospitals, and the oversight that I can implement, or I guess practice, over specifically Health and Hospitals, which is the city system, you know, they're struggling even now after the height of the pandemic.

You know, you have a public hospital system handling the city's entire testing regime.

Even I've heard from numerous advocates and administrators that private hospitals have actively opposed calls to become more involved in community testing.

But we're just not seeing from the State that level of transparency, and even in response to some of your questions over these last few weeks.

And I think when it comes to, certainly, who is, I guess, underserved, I think a lot of the

policy proposals that you have, particularly around the certificate-of-need process and enhanced safety-net investments, that would go a long way to helping rural communities, as well as the communities of color that are concentrated in the city.

So there's a lot there, I think, that we desire in terms of how we can work a little bit better together.

I was hoping the pandemic would -- you know, when I saw that kind of dais of the governor and the Greater New York Hospital Association, you know, I was really hoping that Dr. Katz of H&H would be there, and there would be more unity.

But it seemed to be a lot of the same old.

And I'm hoping that some of your legislative and budgetary action will make a difference, finally.

SENATOR RIVERA: Thank you, Councilmember.

That is all for me.

Back to the Assembly.

ASSEMBLYMEMBER MCDONALD: At this time -- at this time I do not see any other -- oh, excuse me.

Dan Quart.

SENATOR RIVERA: Dan Quart.

ASSEMBLYMEMBER MCDONALD: 5 minutes, please.

ASSEMBLYMEMBER QUART: Councilmember, how are you?

CARLINA RIVERA: I'm doing well.

How you doing?

ASSEMBLYMEMBER QUART: I'm doing well.

Good to see you again.

I have one question, but it concerns budgets.

And I think you have a unique perspective, both on your professional experience before you were elected as a councilmember, and now as chair in the city council.

Obviously, we're all very familiar with the difficulties of the state budget, and the limitations, and so much depending on federal resources being given to us.

But I think maybe, if you could talk to the committee members, and -- about, theoretically, let's say, a 20 percent budget cut to hospitals, and it could be worse, or, hopefully, not as bad.

But in real terms, from your perspective, from the council's perspective, as chair of the Hospitals, what would a budget cut of 20 percent, what would that mean in real terms to our city hospitals, the level care to especially communities

of color that will bear the brunt?

I think if you can speak a little about what that would look like, so we go from theoretical to what that reality would be.

CARLINA RIVERA: Well, I think the cuts would be devastating.

And I will tell you that, coming out of a very long budget negotiation process around the city budget, I mean, I guess it was long -- it was more intense, so it seemed much longer -- and seeing how we had to face the fiscal realities of our state and city budget crisis, and making those cuts across the board to countless initiatives, you know, from housing protections, to geriatric mental health, that was really, really hard to do.

But we realized that, you know, right now, we're in a situation where that kind of financial -- those decisions have to be made.

I think when it comes to our hospital system, we certainly -- that should be the last thing on the table that -- in terms of cuts.

We have seen, in terms of the indigent-care pool, and how that formula for charity dollars hasn't worked for a very, very long time, we see our city hospitals already struggling.

And I will tell that you, pre-pandemic, you know, my relationship with the hospital system was really important.

And they would come to me asking for all types of funding asks.

And I'll give you an example.

I was thinking about this as I was listening to testimony.

They would come to me and ask for things like funding for EKG machines, the renovation of a nurse's station, trauma slots, even work on the facade of some of the busiest hospitals in New York City.

And I just thought, you know, these are things that should be funded by the City and State, no question.

You know, these are our important places -- these are some of the most important places in the city.

Everyone needs quality health care, it's a human right.

But I will tell you, in terms of -- if I could just mention, in terms of City and State coordination, to kind of answer your question, and also Chair Rivera, you know, we need to institute a

more concrete and transparent systemwide emergency response plan, not just in name only, with clear and public organizational framework, chains of command, outlining roles between the State and local municipalities, hospitals, hospital associations.

I mentioned this in my testimony.

But it really needs to be really, really outlined and worked through.

And I think that that formula, and the fact that we don't have enough consumer representation on some of these boards that are making some of the most important decisions in terms of certificate of need, that should all change.

But a 20 percent cut would be catastrophic, considering how our communities of color, specifically with those underlying conditions, we always knew that they deserved more funding.

And to cut those services now I think would be such a disservice to every New Yorker, because we see similarities in other cities and towns and villages all over New York State.

I hope that answers some of your questions, Assemblymember.

ASSEMBLYMEMBER QUART: It does.

Thank you, Councilmember.

SENATOR SKOUFIS: Now -- Senator Rivera had to step away for a few moments, so I'll take over on the Senate side, while he -- until he comes back.

The only other senator we have so far is Senator Hoylman, for 3 minutes.

SENATOR HOYLMAN: Hello. Good morning.

Good morning, Councilmember.

We share a large part of our district together, as well as proximity to New York's great public hospital, Bellevue.

And I wanted to ask you what you knew about the fact that Bellevue was left stranded without PPE. And you and me and other elected officials and volunteers helped bring face masks and gowns.

But at the same time, we were hearing that the private hospitals had access to donors, to members of their boards of directors, that, literally, flew private jets to China to pick up PPE for their administrators and staff.

Can you confirm that that was the case, as far as you know?

And what is your level of outrage at the fact that there was this incredible disparity between our public and private hospitals at the beginning of the pandemic?

CARLINA RIVERA: Well, I think some of my rightful outrage -- thank you for the question -- was because, as often as I checked in with our hospital leaders, you know, I -- of course, Northwell, Mount Sinai health systems, every system is important, and we all should be working together.

My main concern was with Health and Hospitals because of what was going on in Elmhurst and Woodhull and Lincoln, and some of these areas that were really, really inundated.

They would always tell me that they had adequate PPE, but, how we define "adequate" really was left to the discretion of some of those hospital leaders, and some of the, you know, bureaucrats inside the system.

And I found it, you know, wholly unacceptable from what we saw, and, you know, what we were trying to work on.

And I know the State could certainly expedite this, is our whistleblower protections, because a lot of the people that were inside these hospital systems, if it wasn't for the media, we wouldn't have had a clear picture of how exactly dire the circumstances were.

You know, one thing that I did not get to say

in my testimony because of time constraints, was, you know, one thing I think the State can do, is to require the state department of health to review the non-profit status of any hospitals that engage in operations that are more in line with for-profit entities, like -- such as, the provision of ten-figure salaries to executives, massive advertising budgets, and a primary focus on increasing net revenues through increased market share, expansion of the most lucrative patient and health services over necessary, but expensive, low-cost considerations for the local community.

So I think we should really take a hard look at that when we saw those disparities there, while we're all struggling to figure out, you know, how to, you know, expand on reforms to the way Medicaid reimbursement and indigent-care funds are distributed to safety-net hospitals.

I agree with you, I saw places like Bellevue, but really more like Queens Hospital and places in the outer boroughs, communities of color specifically, that were really, really struggling with everyday PPE.

And did it feel good to make those donations?

Absolutely.

But, it was tragic that it came to that, and we couldn't rely on the federal government.

And considering the position we're in now, I just think cuts to the system right now would be devastating.

And I'm hoping that perhaps the State could look at some of these hospitals that are really operating in this really -- this corporate structure that doesn't seem to be the best definition of "public service."

SENATOR HOYLMAN: Thank you.

SENATOR SKOUFIS: Does the Assembly have anyone else?

ASSEMBLYMEMBER MCDONALD: We do.

We have Assemblymember Ron Kim, for 3 minutes.

ASSEMBLYMEMBER KIM: Well, thank you, Chairman Quart [sic].

Councilmember, it's good to see you, and thank you for testifying, and your expertise in this space.

Just to continue the conversation about financing, and the distribution of funds to the hospitals:

It's my understanding that we received some

federal stimulus money for New York City hospitals.

Do you have a better understanding of how that money was distributed; who were the ones that benefited?

And did the communities of color in the outer-borough hospitals, did they receive a fair share of this federal funding?

CARLINA RIVERA: Thank you for this question.

I will say that I -- I'm expecting that they -- there is not necessarily a fair-share formula right now in place on how these moneys are distributed to our hospital systems.

What I would also add, is that my number-one challenge since I became chair of Hospitals was really getting the kind of data and information, specifically on -- in terms of the finances for these hospital systems, not just in time for a hearing to ask thoughtful questions of hospital executives, but just generally.

It's very, very difficult to get some of this information on finances from our hospital system, including Health and Hospitals, which I have direct oversight over in my chair capacity.

So while that type of transparency and accountability has been increasingly difficult, I've

found maybe somewhat of an improvement lately under the tenure of Dr. Katz.

But, really, I don't have an idea of how that money was distributed, specifically to answer your question.

And I find that, as elected leaders, we certainly deserve that information, because I do not think that they received a fair share.

ASSEMBLYMEMBER KIM: And is that a topic that you would be perhaps willing to explore in the city council at another oversight hearing, perhaps?

CARLINA RIVERA: Absolutely.

You know, I've held a number of budget hearings just to extract this information.

You know, and just to give you a quick example, we've even been forced to FOIL some information in the past, which I find ridiculous.

But I would certainly love to host another hearing, and share another hearing on this particular topic. And would be happy to have you testify, or even take your questions directly to some of these executives.

ASSEMBLYMEMBER KIM: Thank you so much, Councilmember.

ASSEMBLYMEMBER MCDONALD: Senator, unless you

have anybody, we do have Tom Abinanti from the Assembly, for 3 minutes.

ASSEMBLYMEMBER ABINATI: Thank you for joining us today.

I share your frustration, as a legislator, who is not be always able to get the administration to answer and provide the information that they should.

I just want to ask you, if you want to comment at all --

I'm sorry I didn't hear all of your testimony. I had another conference call going on at the same time.

-- I'm very concerned about the inability of loved ones to see patients in hospitals and other care facilities.

Do you have any comments on that?

Have you had any complaints about that?

Do you face that at all?

I'm particularly concerned about people with special needs who get pushed into a hospital, and then they lose contact with the world because they're totally confused.

We have had the same kind problem with senior citizens.

Any comments on that?

CARLINA RIVERA: Absolutely.

You know, we -- under the, I guess, some of the guidance of state legislators, we also put forward a letter, asking for our hospital system to consider something like compassionate-care helpers, which is, especially during COVID-19 and the pandemic, we saw people just being isolated with no advocacy.

So trying to put some sort of familial support in the room, someone who can maybe speak the same language, who is culturally humble and understands that some things are harder to express, advocate for or talk through.

And so we've certainly been trying to push for a system that allows, again, that familial support with these people who are very, very sick.

It's happened with our senior citizens, people who speak English as a second language, people particularly with special needs, and certainly our immigrant community.

So when we put forward that letter, and a pilot program was implemented in Health and Hospitals that I believe will potentially become permanent.

It was also looking at some of the guidance, I believe the letter was penned by Lentol in the State House.

So, we certainly want to continue that advocacy.

I mean, I know I even heard from faith-based and clergy leaders, that they were the only people in the room many times, trying to help that person FaceTime a loved one, which is very, very heartbreaking.

So we want to make sure that that situation doesn't happen again in the case of a second wave, or just, you know, throughout the health-services system, ongoing.

ASSEMBLYMEMBER ABINATI: Yeah, I had wanted to ask the commissioner, and didn't -- ran out of time because of our limitations here, about, if he had any numbers to show transmission to patients of COVID from visitors.

When we're talking about nursing homes, there apparently was, according to the nursing home industry, they only had one documented case where a visitor transmitted COVID to a resident.

And I was wondering if there were any numbers with respect to patients getting COVID while they

were in the hospital, and then whether it came from a visitor or somebody on staff.

But I don't know that there are any of those numbers out there without, you know, FOILing them, basically.

CARLINA RIVERA: Well, thank you for bringing that up.

I mean, I've been concerned by the state department of health's lack of transparency and response, certainly to your questions around this over the past few weeks and in your previous hearing.

I think the data behind nursing home transfers, particularly to hospitals, and deaths, must be publically released for an independent review.

And I think this is -- also, this is an issue that has particularly affected maternal mortality during this crisis.

And I want to thank the chairs again for bringing that issue to the forefront and bringing more awareness around it.

But I certainly would be interested in that data.

I plan to request it. I guess if I have to

FOIL it, I will.

And I will certainly be doing a follow-up hearing in my capacity as the chair of Hospitals.

We have a couple planned for September.

And I would look forward to any testimony, questions, or concerns you have that I might be able to address in the chambers [inaudible].

ASSEMBLYMEMBER ABINATI: Thank you.

SENATOR SKOUFIS: Anyone else on the Assembly side?

ASSEMBLYMEMBER MCDONALD: We're good to go.

SENATOR SKOUFIS: Okay.

Thank you very much, Assembly -- Councilmember.

I apologize.

Thanks for being here, and your testimony.

CARLINA RIVERA: Thanks, everyone.

Thank you for your work.

ASSEMBLYMEMBER MCDONALD: Thank you.

SENATOR SKOUFIS: The next panel that we have is the Healthcare Association of New York State, Bea Grause, president, as well as, Kenneth Raske, who is the president of Greater New York Hospital Association.

ASSEMBLYMEMBER GOTTFRIED: Okay. So not to

put any pressure our next few witnesses, just to give people notice --

UNKNOWN SPEAKER: Here's the contact info for Arthur Webb.

ASSEMBLYMEMBER GOTTFRIED: -- after this panel we will be taking a 10-minute break.

But for right now, Bea Grause and Ken Raske, do you both swear or affirm that the testimony you're about to give is true?

BEA GRAUSE: Yes.

KENNETH RASKE: I do.

ASSEMBLYMEMBER GOTTFRIED: Okay. Fire away.

BEA GRAUSE: Okay, great. I'll kick it off.

Good morning, Chairman Rivera and Gottfried, and to your legislative colleagues.

I'm Bea Grause, president of the Healthcare Association of New York State.

We represent non-profit and public hospitals, health systems, and continuing-care providers throughout the great state of New York.

Thank you for this opportunity.

And thank you, the legislature, for your partnership, and thank Governor Cuomo and Commissioner Zucker for their leadership during this incredibly trying time.

But most importantly, I have to thank the health-care workers who have put their patients above all.

This pandemic showed the incredible resilience of all New Yorkers, but also of the health-care delivery system.

Given the right tools, we demonstrated that we can handle any crisis that comes our way.

Every hospital in our state stepped up, urban, rural, large, and small.

Everyone faced daunting challenges; shortage of ventilators, PPE, testing kits, ICU and inpatient bed capacity, but all rose to the occasion.

They shared services, staff, and supplies, partnered to expand testing in their communities, developed best practices for care delivery, and maximized opportunities, such as telehealth.

As the statewide Healthcare Association, HANYS served as a central resource to help hospitals and the State meet the needs of every New York community; it was truly a team effort.

Thanks to decisive actions by the governor, the commissioner, and other state leaders, health-care providers were granted flexibility to respond effectively to this crisis.

In light of the successes shown by the temporary modification of laws, regulations, and guidelines, on behalf of my membership, I am asking the State to make some of these changes, such as telehealth, permanent, so that the benefits can be carried forward for all patients in a post-COVID era.

We're committed to working with state government and all health-care stakeholders to ensure health-care services remain available to all New Yorkers long after this crisis ends.

Our hospitals continue to face very real financial challenges, and we need your continued support.

Hospitals and health systems across New York State have incurred major expenses fighting on the front line against COVID-19.

An analysis completed for HANYS by Kaufman Hall estimates that, through April 2021, hospitals across the state will have suffered between twenty and twenty-five billion in losses and new expenses; a staggering fiscal impact.

While federal funding from the CARES Act has no doubt been helpful, the approximately 9 billion in federal support received through July by New York

hospitals is just a drop in the bucket compared to the financial destruction COVID-19 has left in its wake.

New York's hospitals are all not-for-profit and have the lowest operating margins in the country.

This shortfall will only exacerbate their already precarious financial situation.

Meanwhile, the COVID-19 pandemic has turned what began as a fiscal incertainty earlier this year into a full-blown fiscal crisis in New York.

The 2021 enacted state budget contained 2.2 billion in health-care cuts.

This deficit has grown exponentially since the COVID pandemic.

HANYS and all of our members appreciate the governor's calls on the federal government to do its part and provide the State with necessary funds.

Without this federal support, our health-care providers could face additional deep cuts at the state level.

Additional provider cuts are unthinkable.

We cannot let that happen.

I want to thank the legislature once more for acknowledging the challenges our hospitals have

faced, and continue to face.

Your work during this pandemic has helped support New York's health-care institutions and the dedicated professionals who serve in them.

I want to conclude my remarks by expressing again my utmost appreciation to our health-care workers: nurses, doctors, other direct-care providers, and all those who provide essential services, from food service and laundry, to housekeeping and administration.

Their sacrifices have changed -- have saved countless lives, and provided compassionate care to those in need and their families.

We should all applaud and honor the work, and I know we do.

Thank you very much.

SENATOR SKOUFIS: Thank you.

Mr. Raske.

KENNETH RASKE: Well, thank you very much, Mr. Chairman.

And thank you, Bea.

It's always a pleasure to testify before such a distinguished legislature that we have in New York State.

The Greater New York Hospital Association

represents institutions throughout New York State, many in Connecticut, and many in New Jersey, and even as far away as Rhode Island.

The common ingredient is, they're all large, complicated facilities.

The outline of my presentation has been sent to you. It's mostly a slide presentation. It's separated into two parts:

The surge, the largest deployment of health-care resources in the history of the United States.

So I want you to know that we're bearing witness on something that is immensely historic in the health-care industry.

And the second part, which I'll quickly go through, is the economic consequences, some of which my colleague Bea touched upon.

If I could turn you to Panel 5 in the presentation that we have sent to you, you will see the rolling average of the surge in New York.

And I compared it for you to what you're hearing and reading about in Florida, Texas, and California.

And what you're going see -- what you see, if you take a look at that chart, is that, obviously,

our impact was earlier on, and, therefore, was leading the nation in terms of what we had to find out about this.

But as you can see, it's now ramping up in these other parts, but it's not ramping up to the degree that it has in New York.

In fact, New York's history here on hospital utilization is actually, substantially, and perhaps more than twice as bad, as it is in Texas, Florida, and California, states which are significantly larger than us.

The next panel deals with the coordination among the institutions.

Ladies and gentlemen, I have to tell you, I've spent a lot of time in this industry.

I have never seen more coordination between hospitals -- among hospitals and with state government.

I particularly want to single out state government.

Although we've work with government at all levels, state government was spectacular.

The leadership of some of the people that you had earlier was amazing.

The governor was in a command-and-control

environment.

This is under wartime conditions, and we needed a commander-in-chief, and he distinguished the people of the great state of New York with a great deal of aplomb and accomplishment.

And I'm proud to be a citizen under him.

With respect to the other issues that we have, what you did in order to accomplish this, was to turn the hospital system upside down and inside out.

We put beds -- hospital beds in cafeterias. We put them in lobbies. We put them in places we never even dreamed of ever having beds.

All of that was done.

And Bea's comments about the hospital workers, they are the heros, and I'll never, never forget that, because they put their lives on the line.

Let me now turn you to the question of the economics, and we can drill down substantially into this.

If you can turn to, I believe it's Panel 18 in this presentation, you're going to see, here's the problem:

We cut our volume, deliberately, by

eliminating elective surgeries and ambulatory activity.

Why?

Because we had to move those resources over to the inpatient side.

So there was a super-big revenue loss as a result of that.

Coupled with that now is, will the patients return?

I want you to understand, that a lot of volume has disappeared.

It has -- people have moved out of state.

The attitudes about going to a hospital have been affected.

So we're seeing a decrease in the volume and, therefore, the revenue function.

Also included in that, is that the payer mix has changed, and it is becoming more problematic for our institutions.

Fewer commercial payments as a result.

The transfer to Medicaid because people became unemployed.

Again, Medicaid is a underpayer, so, as a result, putting enormous fiscal pressure on our institutions.

And then the prospect that you've been talking about of Medicaid cuts, well, certainly, that is a reality in Washington that state and local financing may not come through.

Needed financing that we're lobbying for may not come through.

So that is on the horizon.

If it wasn't for the federal government, which I know has been chastised here a number of times throughout the morning, the federal government has really stepped up to the plate, initially.

It is not going to carry the day totally on this issue, but the great work of Senator Schumer, the fantastic work of the delegation -- the House delegation is absolutely amazing.

But here's the bottom line: Every hospital in New York State's going to lose money this year.

The question is, how much?

Thank you.

SENATOR SKOUFIS: Thank you.

And we'll kick it off with the Assembly.

Assemblyman McDonald.

ASSEMBLYMEMBER MCDONALD: Exactly.

We'll start with our chair, Chairman Gottfried.

ASSEMBLYMEMBER GOTTFRIED: Yeah, thank you.

I have a question for -- well, two questions for either, or both, Bea or Ken.

On the question of visiting, and concern about visitors exposing patients to, whatever, seems to me this is not -- while COVID is unprecedented, hospitals have dealt with widespread outbreaks of contagious diseases before, like every flu season.

And while flu is not as fatal, or -- and generally not as serious as COVID-19, for many patients it can be a real problem, and yet hospitals don't eliminate visitation during flu season.

What kinds of procedures do hospitals generally use to protect patients from infection by visitors and, vice versa, to protect visitors from infection by patients?

And what can we learn about that?

And, secondly, not so much a question as just a comment:

When we talk about the need for Medicaid stepping in to protect our hospitals, and all other financing issues, people really need to recognize that that means taxes, and it means taxing, not the people who work on the floors in your hospitals, but taxing the people who are on your boards of

trustees.

But, as a question, I go back to the visitation-and-infection question.

BEA GRAUSE: Sure.

This is Bea. I'll take a crack at it.

And I think, certainly, protecting patients, health-care workers, and visitors is always a top priority, and always has been.

You know, that said, I think this pandemic, we are still piloting in the state. Hospitals are still operating under the visitation pilots that were started probably about two months ago. And -- you know, and I think we're learning a lot.

So we may see some changes.

You know, for example, now, if you're going to visit -- and I visited a patient at Albany Medical Center recently. And I think you have to get your temperature taken, you have to attest that you haven't been exposed to patients that have had COVID.

So I think that there may be more screening, and, certainly, you have to wear masks and good handwashing. And those practices will not change. But, they may wind up becoming more broad-based, I think, as we learn how to operate in what I'm now

calling a "chronically COVID world."

And -- and, again, but I think the goal is the same: It's to protect patients, protect health-care workers, and protect visitors who come into the hospital.

KENNETH RASKE: Mr. Chairman, I'll dovetail on that question on visitation.

Yes, we did the demo, which was limited visitation, and now have expanded that, and encourage all the hospitals to do the expanded visitation, per the demo that was referenced by Bea in her remarks.

So it's limited, but it has the ingredients for the compassion that everybody is looking for in that kind of question.

And that's something that is going on currently.

With respect to tax policy, I'm not an expert in tax policy, but I can tell you this: That, right now, we are lobbying, ferociously, in Washington for the state and local relief for all the municipalities and states across the United States.

Speaker Pelosi addressed our board last week, and we had that privilege of having her join us. And it was something that she and our -- and

Leader Schumer are working diligently on trying to achieve.

That will provide the stabilization, hopefully, if it is accomplished for New York State budget.

Going forward, I worry about the state of New York, and the prospects on the economy, and continued unemployment.

I'm all over this city, I'm all over the downstate area, and I am deeply concerned about the level of employment and the economic recovery.

So we're all going to have our hands full, and we're all going to have to row together, in order to pull this state out of what could be a very dire situation economically, post-COVID, as we go forward.

ASSEMBLYMEMBER GOTTFRIED: Thank you.

SENATOR RIVERA: Assemblymember.

And thank you, Senator Skoufis, for kind of pinch-hitting there for me in a bit.

I'll actually recognize myself for 5 minutes.

Thank you both for being here.

I want to ask a similar question, the one I asked Councilmember Rivera, and that is about the disconnect that sometimes exists between the

administration at the state level and the administration at the city level, and how, you know, with all the caveats that we recognize, that they were difficult times, that we were all under triage, et cetera, I want to get your perspective on whether that sometimes clashing communication styles, to be very soft about it, actually might have impacted the services that were actually provided in the city and the hospitals -- the services the hospitals provided to keep people healthy and safe during those times.

See if I can get your comments on that, please.

KENNETH RASKE: Bea, you want me to start on this one?

BEA GRAUSE: Sure. Go ahead. You start, and I'll follow.

KENNETH RASKE: Thank you for the question, it's an important question.

I could honestly tell you that the level of coordination -- I just touched on it very, very briefly in my oral remarks -- but the amount of coordination between the hospitals, me, specifically, and city hall and state government was a mess.

Every day during the week I would be on with

city hall.

We had an 8 a.m. call with the deputy mayor in charge of health care, and that is day in and day out.

And then we would coordinate what we would know and what they would know, and then what the state government was doing.

So I know it wasn't visible to anybody, because it was just one person here, and another person downtown, and another set of persons in Albany, but the level of coordination was astronomical.

And what were the subjects?

The subjects ranged everywhere, from PPE, to drug shortages.

You know, we were talking about ventilators.

Ladies and gentlemen, there was a real problem on the drugs that would put -- sedate a patient to go onto a ventilator.

So these were wide-ranging subjects that were broached by everybody.

And I have to tell you, you know, we were trying to write up lessons learned on all of this, and we have, and that's actually attached, some of it, to our testimony. But the level of coordination

has been phenomenal.

And it -- sure, it's a little makeshift, and not necessarily visible to everybody.

SENATOR RIVERA: I want to make sure that I give Bea an opportunity as well.

And, just, there is -- because there was, particularly, as it refers to guidance, there was -- there were -- it seemed that, maybe -- as you said, maybe we weren't seeing it, but to us, many of us on the outside, it looked at times that the administrations were clashing. And that whether it was the mayors -- and this is no secret. Obviously, there have been some, as I said, communication styles might differ, or what have you.

But my concern, again, because these hearings are about two things: they're about accountability and forward-looking policy.

So how can we best -- so, Bea, I certainly want to get your input here.

BEA GRAUSE: Sure. Yes.

SENATOR RIVERA: But just to be clear, so what we're looking for is, like, how can we best make sure that this coordination actually functions, to not -- you know, to make sure that people are -- you know, are healthy and safe.

Go ahead, Bea.

BEA GRAUSE: Yes.

Yeah, and I think to build off of what Ken said, we've worked together on lessons learned. And we've been working with the administration and the department of health on -- you know, on the planning for PPE in the fall surge; a lot of that.

And we're very forward-looking at this point.

You know, and I think in response to the clashing, you know, I think it's important to put it in context.

You know, during the two-plus months, from March through May, it was all hands on deck all the time.

And, was it perfect communication?

I think there was a lot of clarification and redundancy sometimes, or maybe gaps in communication.

So there was a lot of phone calling and a lot of back -- you know, checking.

And I think that's part of the lessons learned, as we go forward, and think about how to be better prepared, to make sure that we're really clear on communication at the local, state, city, and state -- and state regional level.

So I think -- again, I think there was tremendous, tremendous effort, dedication, collaboration, as Ken said. And -- but we can always do better.

And I think that's really what the focus is now.

SENATOR RIVERA: Thank you.

And in the last 20 seconds I'll just say, just like -- as I said to the commissioner, I want to make sure that there's -- and I know from you folks there's a commitment.

I want to make sure that safety-net hospitals, that are the ones that serve the folks that are most at risk, that were most at risk before the crisis, there were some of them in crisis before the crisis, they still are there. Now they're in an even worse situation.

Let's make sure we commit all ourselves to make sure that we provide, so that they can continue to exist and serve those communities.

BEA GRAUSE: We need federal funding.

SENATOR RIVERA: And we need more revenue from the state.

[Indiscernible cross-talking.]

SENATOR RIVERA: We need more revenue from

the state.

BEA GRAUSE: Yep.

My time has expired.

Assembly.

ASSEMBLYMEMBER MCDONALD: My time is on.

I will elect to speak for 5 minutes.

And, Ken and Bea, thank you both for your testimony, and thank you for your shout-out for all those who are on the front lines caring for individuals.

Bea, I guess this question is more directed towards you.

You had mentioned appropriately about the fact that we're looking at an exposure of $25 billion, and $9 billion was provided by the federal government.

I should know, but I don't, how that was distributed.

Do you have any idea how it was distributed amongst your member organizations?

BEA GRAUSE: Yes. But it -- you know, and we can certainly provide that to you offline. It's quite complicated, actually.

There have been -- oh, gosh, I would say six tranches of distribution in the fund. There's

$52 billion remaining in the fund.

But there were hotspot distributions, rural distributions, safety-net distributions, and all formula-driven, somewhat in a black box, I guess I would say, from HHS, in terms of how they made those calculations.

But they have done that over time, and are continuing to do that.

And, obviously, in the legislation that's pending now before Congress, we are hoping that they add to the Provider Relief Fund so that there are additional dollars to come to New York.

ASSEMBLYMEMBER MCDONALD: As you know, and probably as part of your testimony that's written, that I haven't reviewed yet, many members, particularly in the upstate, are lamenting the fact that they feel that there wasn't enough support for them.

As you know, with the hospital capacity, our bed-capacity rules, a lot of elective surgeries, which really weren't elective, they were necessary, were put off to the back burner, and lost revenue, which is critical when you look at the operations.

And that's my comment.

Thank you very much.

Back to you, Senator.

SENATOR RIVERA: All righty.

Now recognize Senator Tom O'Mara for 5 minutes.

SENATOR O'MARA: As I'm talking [inaudible] --

SENATOR RIVERA: Unmute yourself, sir.

You muted yourself.

Now you're good.

SENATOR O'MARA: I did it twice.

Thank you.

Thank you both for testifying here today, and I as well want to commend the hospitals across New York State, in their phenomenal response to the needs from this pandemic, and the increase in hospital beds across the state.

So thank you for all of that.

And with the volunteering of ventilators and other PPEs and other equipment to those hospitals that were stressed, to what extent have ventilators and other equipment that was loaned out, so to speak, been replaced to your hospitals, or have you been reimbursed for those supplies and ventilators that were provided?

BEA GRAUSE: They're all back --

SENATOR O'MARA: They're all back?

BEA GRAUSE: -- all hospitals.

Yep, they're all back.

SENATOR O'MARA: You as well, Ken?

KENNETH RASKE: Yes, absolutely.

SENATOR O'MARA: So they're back.

KENNETH RASKE: As far as I can determine.

We've done an inventory of serial numbers, and all the rest of that, supplied it back to the State.

And, you know, there -- on the ventilator issue, I have to tell you, there's two things I have a quick comment on.

Number one is, the coordination between the City, State, and us was phenomenal on the ventilators.

You know, the -- Larry Schwartz, former secretary to the governor, a volunteer, did a magnificent job in helping us access ventilators on that basis.

But, you know, there are problems.

A lot of ventilators came to us without tubing.

You'll see in one of the books that Mike Doweling wrote at Northwell, and I'm holding it

up here, which is probably good reading about handling the pandemic, Mike said, you know, that they had to go out to, basically, hardware stores to get tubes.

Well, you know, we did that, and we did makeshift things in order to make things work.

So my feeling is, is that this is a story that needs to be told.

And recognition for innovation and heroism has gone unrecognized among our colleagues and all of the workers within the hospital community.

SENATOR O'MARA: But I certainly recognize the efforts that went into the great work that was done.

So I appreciate the work of all the hospitals across the state in what was done.

KENNETH RASKE: Thank you, sir.

SENATOR O'MARA: Do the hospitals in your associations, are they aware of how many patients that came from nursing homes ultimately died within hospitals?

KENNETH RASKE: Bea, do you know if they -- I'm not -- I'm sure that we have source of origin, obviously, for the patients that came in.

But a statistic that I'm available to, right

now I have no idea.

SENATOR O'MARA: Okay.

So the state department of health has been not forthcoming with this type of information that has been a critical issue in our review of this.

What information do hospitals keep on hand, and what is provided to the department of health, as far as statistics on where a patient comes from?

Is it noted that they come from a nursing home?

And what records can we request to get that information?

KENNETH RASKE: Bea, do you want to try that?

BEA GRAUSE: Sure.

Well, certainly, hospitals do collect quite a bit of data.

I would have to go back and look at the details to understand -- really understand the depth of your question, which I'm happy to do.

KENNETH RASKE: Yeah, I don't have -- you know, the problem is, I don't have -- I don't know, either.

But the amount of information we have on patients is astronomical.

So I would probably guess we would know where

the patients came from, how they came into the ER, point of pickup, and all of that, is somewhere in the level of documentation, sir.

So -- but is it readily available to either Bea or me? I don't -- we both say no.

BEA GRAUSE: Yeah.

SENATOR O'MARA: Okay.

But your hospitals report that to the department of health?

KENNETH RASKE: I don't know.

SENATOR O'MARA: You do not know?

KENNETH RASKE: I don't know.

SENATOR O'MARA: Okay.

Did you -- what have you seen now with your hospitals since the elective surgeries and other procedures have been opened up in the hospitals after they were closed down?

They were kind of slow to resume.

At what capacity do you think you're seeing now in hospitals, with patients returning for these elective procedures, and whether there's still a general reluctance to go to the hospital for fear of contracting COVID in the facility for those procedures?

KENNETH RASKE: You know, that's a great

question. And we just finished a poll, sir, on that.

And --

SENATOR RIVERA: Quickly, quickly, Ken, since his time has expired. But I'll let you answer. Go ahead.

KENNETH RASKE: Okay, well, I'm just trying to answer the question.

In our display we have a poll of attitudes of New Yorkers.

This is a -- 1200 people were polled across New York State. 800 in the downstate area, so oversampled there.

And we asked the question about your attitude towards being hospitalized, or going to a hospital, going to a doctor.

If you take a look at Panel 19, you will see that the remarkable results, and this has changed over a period of time, on the --

SENATOR RIVERA: We will do, we will do that, on page 19 in the document that we have all received.

We just have to make sure we move on, Ken.

Sorry about that.

Assembly.

ASSEMBLYMEMBER MCDONALD: We will move on to Ranker Kevin Byrne for 5 minutes.

ASSEMBLYMEMBER BYRNE: Thank you.

And thank you for being here to provide your testimony this afternoon.

A couple questions, just to follow up on Senator O'Mara a little bit.

Did you find that the nursing home admissions to any of your hospitals, or your members, was a significant challenge, factor, in staffing capacity, or severity in the response to the pandemic?

BEA GRAUSE: No.

It would be no.

I mean, I think our hospitals were equipped 24/7 under any circumstances to care for any patients.

So, admitting patients from nursing homes was just part of what they do.

KENNETH RASKE: Yeah, I would only say that, you know, the staffing issue, it warrants a considerable amount of attention.

Again, I have a whole paper, which is attached to our testimony, on staffing issues.

But we -- we -- during the height of the epidemic, and the pandemic, we were stretched very

thin.

Ladies and gentlemen, I want you to note, everything has a breaking point.

And if you take a look at the uptake of the pandemic in New York State, and match that against Florida and California and all those other places, we were probably within 5 to 7 percent of the breaking point.

So, sir, to the question: What does the "breaking point" mean?

"Breaking point" means, literally, you put people in the hallways.

That's what it could mean.

Does it is mean you triage people going out to vents? In other words, you're making life-and-death decision about who is going to go on a ventilator?

That's how close it came in relationship to this, and the key here was the staff.

Did we have enough staff at the height?

Yes, but, if we pushed it, we could have hit a breaking point.

And that is the hard, cold reality of what went on here.

And that's including the 12,000 or

13,000 people that came in through the State's great efforts. People came in from all over the United States to help us out.

And you know what?

It wasn't enough even as we approached the worst point.

ASSEMBLYMEMBER BYRNE: Thank you for those comments, and I can definitely relate.

I represent Westchester County as part of my district.

And Westchester, and specifically New York City, those hospitals, I could tell, just anecdotally, speaking to staff and folks that I know, they were very, very stressed.

And I commend you and your members for all the work, and your staff, for what they've done throughout this pandemic.

Senator O'Mara asked about numbers and data.

So I'm not sure exactly, and I understand you may not know exactly what was reported to the department of health.

But if you were asked by the department of health, or perhaps the legislature, do you believe you could provide numbers as to the fatalities that occurred in hospitals, and where they came from,

including if they had occurred -- they came in from nursing homes?

Is that something you could provide if asked?

BEA GRAUSE: Didn't Commissioner Zucker say that, I think, at the end of the pandemic, that he would provide more data?

We certainly are willing to take a look at what data we can compile, and provide that.

But I think the commissioner said that he would be doing it.

KENNETH RASKE: You know, my staff -- my staff gave me a note here, sir, to that question.

They said, I'll read it to you, but I have no idea if this is true or not.

But, ultimately, reported by hospitals in SPARCS claims data, but there is a time delay.

BEA GRAUSE: Yeah.

KENNETH RASKE: I don't know what that time delay is.

That's what our staff says here in New York.

ASSEMBLYMEMBER BYRNE: Certainly not real time.

KENNETH RASKE: Not real time.

ASSEMBLYMEMBER BYRNE: And I agree with the comments you referenced from the commissioner.

I'm just -- I want to make sure this is something that we can ultimately access. And if it's -- if we're going through all these hoops and hurdles with the department, if this is something that maybe -- you know, we want to make sure it exists, and that we can obtain this information, to get a complete picture, so we can craft better policies and just do the best job that we can.

A question about, just regulations in general.

A lot of things may have been suspended through executive orders, directives, as a way to increase hospital capacity.

It was a question I asked the commissioner earlier, and this is kind of an open-ended question for any of you.

If there are things -- I know, obviously, funding is a big piece that we've heard about, federal and state support.

But is there any other regulations or restrictions from the State that could be revisited, to increase hospital capacity and allow to you care for more patients?

BEA GRAUSE: Yeah, I think, generally, flexibility, as a principle, is really, really

important. And I think we learned that during the pandemic.

I think, in particular, any permits for, you know, certificate of need.

All of the changes that happened with telemedicine, which our members were amazing in how quickly they stood up telemedicine centers, and really started transitioning over to telehealth appointments, everything, from pediatrics to psychiatry.

So I think that kind of flexibility, and being innovative, regulations that allow innovation, is something that we'd like to see more of --

SENATOR RIVERA: Thank you so much.

BEA GRAUSE: -- and have more of a [indiscernible] conversation about that.

SENATOR RIVERA: Thank you, Ms. Grause.

Thank you, Assemblymember.

Currently, there are no senators on deck.

ASSEMBLYMEMBER MCDONALD: And we have two assemblymembers.

And we will to go Ranker Brian Manktelow.

ASSEMBLYMEMBER MANKTELOW: Thank you.

Ken, just a quick couple questions for you.

I was looking at your teetering point there,

financially, for the hospitals.

KENNETH RASKE: Uh-huh?

ASSEMBLYMEMBER MANKTELOW: And being a business -- former business owner, and farmer, and understanding money and budgets, you know, we know that cost [indiscernible] are going to go up.

We know that; we know it's going to happen.

We know that the revenues are going to be, you know, down; the volume, the payer mix, the Medicaid.

What are some things we can do here in New York State -- let's leave the federal government out of it, let's just talk about New York State -- what are some of the things that we can do to help our local hospitals, especially in our rural areas where the numbers are going to go down.

You know, we have people leaving this state in droves, and those are part of that payer mix. They pay a lot of the bills, these people that are leaving.

And what can we do legislatively, or, just in general, in New York State to help us get over this hurdle?

It's coming, it's going to be a big hurdle.

KENNETH RASKE: Yeah, you know, thank you,

sir, for the question.

That really requires a very studious answer on my part, and I would be more than happy to make a listing of suggestions, which we can get to the respective chairs and co-chairs, as well as the things that can be done.

Right now, we're only beginning to see the breadth and depth of the potential problem, and our hospitals have to cope with it immediately, sir, as a business -- as a business.

And this doesn't make any difference, whether it's public or private hospitals, we're going to have to cut costs. We're going to have to get costs out of the cost structure of our institutions.

And I'm desperately worried about how best to do that at this particular time.

And -- and -- and -- and if I could find a way to make recommendations to the New York State Legislature and Executive Branch of how best to do that, and help us, I will do that.

And I promise to you, I will get that to you at this point.

But, right now, I know that some of our hospitals are contemplating layoffs.

Now, can you think of the conundrum that

we're in?

We just asked our staff to do heroic things, and now we're going to turn around -- because our revenues have collapsed, and we're going to turn around and send out a layoff notice?

How terrible is that?

How terrible is that?

And -- and -- but, the balance, the revenue, and you all have to understand this, the revenue is collapsing.

And will that mean -- and I'm going to go right to the point: What does that drive to?

And, Chairman Rivera, you asked the point about safety-net institutions.

They're on the bubble.

David Pearlstein is going to follow us. Right? David runs St. Barnabas Hospital.

He does a super job under a tremendously difficult situation.

And we are facing a growing crisis, and that is unfolding at this point.

How fast we get the patient base back, how fast we get the payer mix back, what relief we get from Washington -- question mark, question mark, question mark.

I don't have any great answers, sir, to the question.

You asked.

I will try to help -- I'll try to figure out ways that we can send you some meaningful suggestions on how best to get costs out of the health-care system without damaging our health-care services.

I will do that.

ASSEMBLYMEMBER MANKTELOW: And I think that's why, through this pandemic, we, as legislators, especially in the rural upstate areas and up north, you know, we should have took a different approach with the hospitals, because some of our rural, rural counties, we just didn't have the volume of COVID patients.

We should have allowed some of those hospitals to possibly operate, very carefully, with other -- you know, with other areas of the state to make sure that happens.

And sometimes, again, New York State, one size fits all, doesn't work.

I feel so sorry for the hospitals, the staff, and the patients in the New York City area. They were just deluged with what was going on.

But that's where we need to work together with the other parts of the state, and making sure that we, as legislators, Senate and Assembly, are engaged with our governor, to let him know that we are -- we can be open because we don't have the pure volumes.

And this is going to affect all of New York State.

And I don't want to see one hospital close, I don't want to see one -- one person get laid off, because they were the front-line units that were taking care of all of our people during the pandemic.

KENNETH RASKE: Absolutely, I'm with you, I don't want to see one person laid off, too.

ASSEMBLYMEMBER MANKTELOW: So, get me that information, and I would love to take a look at it. And I would love to get back to you, and talk about that in the near future.

Thank you.

KENNETH RASKE: Yes, sir.

BEA GRAUSE: And I'd like to add, that our hospitals are our economic engines in many of these rural communities.

And I think providing them with regulatory

relief, but, also, looking for ways to help ingrain the hospital, really, more as part of the community in terms of goods and services that can be provided to the hospital, and then back again into the community, I think is one way to promote economic development upstate.

SENATOR RIVERA: Thank you, Ms. Grause.

BEA GRAUSE: I think it's something we should double-down on.

SENATOR RIVERA: Thank you, Ms. Grause.

Thank you, Assemblymember.

Next I'll recognize Senator Skoufis for 5 minutes.

SENATOR SKOUFIS: Thank you very much.

And thanks to you both.

As some of my colleagues have noted, I want to really applaud and acknowledge your members.

In my area, St. Luke's Cornwall, Orange Regional, did phenomenal work over the past five months, among others, and really nimble work. Right?

I mean, it seemed like, every day, hospitals needed to respond to a new directive, new guidance, new circumstances, and in previously unthinkable situations.

So thanks to you and your members.

To that point, as we try and assess the past five months, and look at, you know, perhaps some things that are now in place that weren't in place before, that may be worth keeping in place, can you speak to, maybe, some lessons learned, some -- either through directives or through guidance or through just voluntarily doing things differently yourselves?

What are some things that have been changed internally with your members these past five months that are worth keeping around permanently?

Similarly, is there a directive or two, is there some sort of State action, that you think -- and hindsight is 20/20 -- but that you think, you know, should have been reconsider -- or, should be reconsidered if there is a next wave or a next pandemic?

So if you can maybe pick one or two items from each of those lists, and briefly share, so that we, as a legislature, can sort of get that guidance from you as we move forward.

BEA GRAUSE: Sure.

I'll kick this one off, and then kick it over to Ken.

I think as Ken and I have both said, I think our very talented teams have done a lot of work, talking to our members, where we have identified lists of lessons learned, and things that we want to continue to make the system better.

And a lot of those revolve around clarifying roles, improving communication.

Obviously, you know, focusing on a potential surge, and figuring out how to, you know, stockpile PPE.

A lot of workforce issues, in, you know, sharing staff, and a whole host of patient-care issues, I think that we can address to make sure that we are even more flexible, more nimble, and more collaborative when and if the next pandemic comes to New York State.

So we have -- we have done that work.

We're happy to share that with you.

And so --

SENATOR SKOUFIS: Please do.

I would love to see that list that you're referencing of lessons learned.

And is there one or two -- are there one or two State actions that you wish were handed down a little bit differently?

BEA GRAUSE: I can't think of anything off the top of my head.

Maybe if Ken comes up with one, I'll chime in. But, I'll turn it over to Ken.

KENNETH RASKE: Well, thank you, Bea.

I can't think of any, either.

Attached to my testimony is patient-load reduction.

It was an earlier question that was asked, I think of a number of panelists as well.

And if you go into that document, it deals with, how do you best take care of the situations that we were confronting within a hospital system, and then from one hospital system to another?

We have a data mechanism in New York that we put together called "SitStat," which has a way of working with the EMS people, who are terrific to work with, and how to balance these EMS ambulances going to institutions that are overloaded with -- in their ED, and how to redirect them to other institutions.

And that's some of the suggestions that we have.

But as it relates, sir, to the question, State action? I can't think of any at this

particular point.

So I would join with my colleague Bea and say that, we'll ask our staffs, and I'm sure they probably are smarter than we are, to come up with suggestions, and we'll get them to you, sir.

SENATOR SKOUFIS: Very good.

Hey, thank you; thank you both.

SENATOR RIVERA: All right.

Thank you.

Assembly.

ASSEMBLYMEMBER MCDONALD: Ron Kim, 3 minutes.

ASSEMBLYMEMBER KIM: Thank you.

So I understand that, during this pandemic, especially in March and April when everyone was scrambling, many health-care facilities called on groups like yours to help with PPE supply.

Did your organizations allocate funds to purchase and distribute PPE to your members?

KENNETH RASKE: Well, that's an interesting -- you know, there's --

BEA GRAUSE: I'm sorry. I didn't hear the question.

ASSEMBLYMEMBER KIM: Did you purchase and distribute PPE to your members, you know, when things were rough back in March and April?

BEA GRAUSE: We did receive federal funds that we used, that our members -- that we passed through to our members, that our members used to purchase PPE.

ASSEMBLYMEMBER KIM: But not directly from your association funds?

BEA GRAUSE: No.

ASSEMBLYMEMBER KIM: No.

BEA GRAUSE: We did not.

KENNETH RASKE: You know, that's a very interesting question.

We just sold -- Greater New York has a number of for-profit businesses, and one of the businesses we sold was a consulting firm to a national group called Premier, Inc. And they have -- they do purchasing, sir, for 2500 hospitals across the United States.

So we maintained a significant informal relationship with that group, to assist our hospitals. And they ended up -- for all practical purposes, they ended up providing services to about 70 percent of the hospitals in New York State.

ASSEMBLYMEMBER KIM: Thank you, Ken.

Well, the public records do show that your associations did allocate nearly $500,000 during

this pandemic toward political contributions in Albany, which is nearly double the amount from 2018 around the same cycle.

No one in this hearing or the people listening in is naive about how political contributions provide access, you know, to co-create policies and regulations.

You know, for example, on April 2nd, the Greater New York Hospital sent out a press release about how you successfully drafted and passed a broader legal immunity law that retroactively covers non-COVID cases, and also protects hospital CEOs, board members, et cetera.

Besides the legal immunity law, did your associations draft or lobby any other policies, regulations, or even executive orders, during the peak of this crisis?

KENNETH RASKE: Sir --

BEA GRAUSE: [Indiscernible cross-talking] --

KENNETH RASKE: Bea, let me answer that question because this is more directed at me than at you.

The -- the -- first, let me clarify one thing.

We spent $8 1/2 million, sir, on an ad

campaign to allay the fears of New York public to go back to the hospital.

So, that number, and that is attached in our testimony today, so you can see that.

So political contributions are small in comparison to the public-service messages we put forward.

That's one.

Number two, I want to be perfectly clear to you, the following: That we lobbied extensively for the immunity law, and I'm proud to have done it, and continue to do it right now in Washington as it relates to the federal level.

But, when you say that we wrote the law, that's not true.

And let me do this clarification --

SENATOR RIVERA: Very quickly, sir.

KENNETH RASKE: -- on the record, under oath.

I want to do this, because I have to.

SENATOR RIVERA: Go ahead.

KENNETH RASKE: And -- and -- and what we have done was the following:

We gave a draft to the executive branch of some ideas to be included.

We share drafts of legislation with many of

you on a routine basis in the Assembly and the Senate, and in Congress, and in the executive.

That's nothing new.

So we did that.

Was that draft ultimately different than the law?

Yes, and materially different.

So we did not draft the law.

So as a result -- but we had a memo, and this is what you're referencing, sir, and I appreciate for you bringing it to the public's attention, we had a memo which we [indiscernible cross-talking] that issue.

And I went on the record with my board last week and made that clarification.

And now that [indiscernible cross-talking] --

SENATOR RIVERA: Thank you, Mr. Raske.

Thank you, Assemblymember.

I want to make sure we -- we have a senator on deck.

I recognize Senator Biaggi for 3 minutes.

SENATOR BIAGGI: Thank you very much, Mr. Chair.

Thank you both for being here to testify with us today.

My question actually piggybacked off of Assemblymember Kim's.

So now that we're all in the realm of immunity, and to your point, Mr. Raske, that you have -- you provide, historically, drafts of legislation to legislators, as well as others, is it fair to say that you provided a draft of the immunity provision to the executive branch?

KENNETH RASKE: I just said that.

Yes.

BEA GRAUSE: And we did, too.

SENATOR BIAGGI: I'm making it clear: Did you also provide the draft to the department of health commissioner?

KENNETH RASKE: Oh, I don't know about that.

We gave it to the executive branch.

I don't remember ever giving it to the DOH.

SENATOR BIAGGI: Have you had any communications, prior to the passage of the budget, with regard to the immunity provision with the department of health commissioner?

KENNETH RASKE: Could you repeat the question?

SENATOR BIAGGI: Did you have any conversations with regard to the immunity provision,

prior to the passage of the budget, with the department of health commissioner?

KENNETH RASKE: Well, you know, our legal counsel was in contact with legal counsel of the executive branch.

I don't know what that all transpired in terms of discussions.

So she was the one that would have had any discussions at all.

As it relates to me, I don't have discussions about that, that level detail.

SENATOR BIAGGI: So then we will follow up on that, to determine whether communications were actually made, and that will be part of the 21-day follow-up questioning that will come from me.

KENNETH RASKE: Yeah, I can -- well, she's actually in the room. I mean, you know, I'll ask her.

I don't know.

SENATOR BIAGGI: Okay, very good.

Thank you.

And just to be super-clear, the press release that Assemblymember Kim is referring to, that was later deleted by Greater New York Health, actually stated, quote, That Greater New York Health drafted,

and aggressively advocated, for the legislation.

But you have just stated that Greater New York Health did not actually draft the legislation.

So, which one of these statements is true?

KENNETH RASKE: No, I -- I'm going to be very clear:

We gave the executive branch a draft of legislation -- okay? -- a provision.

That draft is not what was the final law.

It was extensively changed and increased in terms of breadth.

So to say that we drafted it would be wrong.

However --

SENATOR BIAGGI: Okay. So the [indiscernible cross-talking] --

KENNETH RASKE: However, what you're referencing was a member's letter that was sent out, which reflected a misstatement on our part, of that.

We should have just simply said --

SENATOR BIAGGI: Okay. Thank you for clarifying that.

KENNETH RASKE: -- we gave them a draft --

SENATOR BIAGGI: I just have 30 seconds left, I just want to ask this final question because it's

very important.

I appreciate you answering that question.

So, just throughout the conversation here with all of the other members, there's a real emphasis on a budget deficit.

And so, you know, the state is obviously deeply dependent on revenue.

And without a clear indication of whether Washington is going to provide aid to localities and municipalities, what exactly do you believe the best plan is?

And, do you believe we should be raising revenue in the state of New York to make sure that we deal with this budget shortfall?

KENNETH RASKE: Bea, do you want to try that first?

BEA GRAUSE: No, I -- I think that we don't have the ability to close a deficit without federal revenue.

So I think we have to wait for that first, and really work together to see if we can get Congress to act.

SENATOR RIVERA: Thank you, Senator.

SENATOR BIAGGI: That doesn't answer the question --

Thank you very much.

SENATOR RIVERA: Thank you, Senator.

Assembly.

ASSEMBLYMEMBER MCDONALD: We have Assemblymember Andrew Garbarino.

ASSEMBLYMEMBER GARBARINO: Thank you.

Thank you, Chairman.

Thank you both for testifying today.

I just had two questions.

You both briefly spoke about fiscal stress from COVID in your testimony, due to, I think, the cost of PPE and loss of elective surgeries.

Is there anything currently now that your members aren't allowed to do, due to government intervention, that you think you guys can do safely?

You know, like, I know you can do elective surgeries again.

Is there anything else that the State is stopping you from being able to do to help -- to help you guys get funding in?

BEA GRAUSE: This is Bea.

I don't think the State is preventing, you know, services, or anything from -- that are -- that is preventing hospitals from generating revenue.

I think we are just hoping to get relief

funding from the federal government.

But the State is not standing in the way, as far as I'm aware of.

You know, we're certainly working with the State to comply with regulations around planning for a fall surge. And that is taking up some bandwidth in hospitals, but it's not -- but it's not preventing them from operations.

KENNETH RASKE: Well, I would say, Bea, on that score, what we do with the State is partner.

BEA GRAUSE: Yeah.

KENNETH RASKE: We are preparing for a second wave, make no mistake.

We're making sure that we have enough PPE, we have enough drugs, we have enough equipment, and so forth and so on.

And I'm worried about the mental-health status of our employees on top of it. They have been under great stress.

And, you know, we're working with a number of organizations, DoD, the AMA, to try to figure out ways to help relieve their stress levels.

But at this particular time, I don't see that the State of New York is an impediment to anything. I treat them as a partner, a full-fledged partner,

all the way.

ASSEMBLYMEMBER GARBARINO: Great.

And just another one.

During the crisis high point, we changed -- the Javits Center was changed to COVID-only.

Do your members believe that they -- if there is a second phase and an uptick, do your members believe that they should be the first stop for COVID patients, or should we directly go to a COVID-only field hospital?

Do your members believe they're preparing enough and they'll be able to handle the uptick --

KENNETH RASKE: Remember, the Javits and the "Comfort," both, were, basically, nothing more than safety belts.

And I think the commissioner remarked, you know, they also had prepared, but we didn't use, Westchester, and there was a number of places out on the island as well.

These were all to be safety belts in case we got to the breaking point that we were -- that I referenced earlier.

But, also, the "Comfort" was not going to take COVID patients initially.

ASSEMBLYMEMBER GARBARINO: No, yeah, I know,

but --

KENNETH RASKE: And that was a Department of Defense decision.

And my guess is, you know why? They didn't want to have the sailors get infected, and, therefore, reinfect others across in the U.S. Navy.

So, I mean -- but --

ASSEMBLYMEMBER GARBARINO: You guys should be the first stop, though, is what I'm saying?

KENNETH RASKE: The hospitals, clearly.

[Indiscernible cross-talking.]

KENNETH RASKE: Even on the "Comfort," they were not equipped to do isolation.

ASSEMBLYMEMBER GARBARINO: That's [indiscernible cross-talking] --

SENATOR RIVERA: Thank you, Mr. Raske.

Thank you, Assemblymember.

ASSEMBLYMEMBER GARBARINO: Thank you very much.

SENATOR RIVERA: Thank you, Assemblymember.

Currently, no members of the Senate to ask questions.

ASSEMBLYMEMBER MCDONALD: And we're clear on the Assembly.

SENATOR RIVERA: I believe -- actually,

I believe that Assemblymember Quart might have raised his hand at some point?

ASSEMBLYMEMBER MCDONALD: And he lowered it.

SENATOR RIVERA: Did he?

ASSEMBLYMEMBER MCDONALD: He lowered it.

SENATOR RIVERA: Oh, he lowered it?

ASSEMBLYMEMBER MCDONALD: We verified that, yep, we verified that.

SENATOR RIVERA: Very well.

All right.

So with that, I will thank both of you for being part of these hearings. And we might have some follow-up questions for you, that we [indiscernible cross-talking] --

KENNETH RASKE: Yes, [indiscernible cross-talking] --

BEA GRAUSE: Absolutely.

SENATOR RIVERA: Thank you both.

Thank you, Senator, and thanks to the legislature.

KENNETH RASKE: Thanks very much.

SENATOR RIVERA: Thank you, both.

Moving on to Panel Number-- oh, actually, I'm sorry.

We had talked about this before.

We will take our first 10-minute break for the sandwiching and the toileting, not at the same time.

10 minutes, ladies and gentlemen.

Thank you.

(A recess commences.)

(The hearing resumes.)

SENATOR RIVERA: Welcome back, everyone.

We will now be moving on to Panel Number 4.

We are joined by Veronica Turner-Biggs, executive vice president of SEIU 1199, who will split her time with Arelda [ph.] Arleda [ph.] Moore, who's an environmental service worker, from the Garnet Health Medical Center.

We are also joined by David Van de Carr, 1199 member, and a respiratory therapist at Mount Sinai Morningside.

And, last, but not least, Judy Sheridan-Gonzalez, a registered nurse, and the president of the New York State Nurses Association.

ASSEMBLYMEMBER GOTTFRIED: Okay.

And do each of you swear or affirm that the testimony you are about to give is true?

VERONICA TURNER-BIGGS: I do.

DAVID VAN de CARR: Yes, I do.

JUDY SHERIDAN-GONZALEZ: I do.

ASSEMBLYMEMBER GOTTFRIED: Okay. Fire away.

SENATOR RIVERA: Thank you, sir.

Veronica Turner-Biggs.

Ms. Turner-Biggs, go ahead.

VERONICA TURNER-BIGGS: Thank you.

Good afternoon.

I am the downstate health systems senior executive vice president for 1199, United Healthcare Workers East, leading our work with over 100,000 health-care workers in hospitals in New York and Long Island.

I appreciate the opportunity to speak to you all today, and appreciate the opportunities that you are granting to allow our members to speak directly to you.

1199 hospital members do everything, from advanced critical care, to keeping facilities clean. They include nurses, dietary aides, environmental service workers, medical assistants, and laboratory technicians, as well as a whole host of other roles that provide compassionate care, and keep patients safe, and they were on the front line of this pandemic.

Our members were sick, and some still are.

They face tremendous fear and anxiety, and had experiences that left lasting trauma.

Many suffered financial hardship, as they spent their own money to stay in hotels and take cabs to work to keep their families safe.

Some members and members of their families passed away, including a number of our union delegate leaders.

As you probably know, just as in the general population, workers of color were disproportionately affected by the pandemic.

These essential workers are heroes, and the routine nature of their work exposes them to illness and disease.

But we should never again -- we should never again -- tolerate workers entering a hospital without the tools to keep patients and themselves safe.

We've heard the stories about PPE shortages and shifting guidance, which undermined worker safety, but there are other parts to this story.

Within hospitals there were often a hierarchy of access to PPE, particularly with N95 masks.

Bedside clinicians were the priority, while ancillary staff, who also had patient contact, often

did not receive N95.

And among hospitals, there was also a hierarchy of access, with Manhattan hospitals having better access to PPE compared to the outer boroughs.

These are just some of the challenges members faced during the pandemic, but we must also recognize how hospitals and hospital systems collaborated with and supported their workforce during such a challenging crisis.

Our union is reflecting on what happened.

And as we've begun to capture the COVID-19 best practices, fortunately, it is a long list, and they fall into a couple of broad categories that include:

Early identification and communication about patients and staff who may be exposed;

Accessing stockpiling, and training all staff with PPE;

Collaboration and communication with labor partners at all levels, and focus on problem-solving, including daily reporting;

Attention to the full range of support that workers need to do their jobs in an unprecedented environment of school closures, questions about the safety of mass transit, and the real potential of

bringing a deadly infection home from work.

This pandemic has really tested our hospitals and state's ability to respond to an emergency of this breadth and scale.

Rank-and-file hospital workers, among others, responded to the challenge heroically, and at great personal sacrifice.

We must honor their dedication by learning the hard lessons from their experience and dedicating the resources needed to enact change.

You are now going to hear from two of our member leaders, and you have my full testimony.

Thank you.

SENATOR RIVERA: Thank you, ma'am.

And we are now going to be joined by Arelda Moore -- Arleda [ph.] -- Arleda Moore.

Apologies.

It's Arleda, or Arelda?

ARDELA MOORE: Ardela.

SENATOR RIVERA: Arleda [sic] Moore.

ARDELA MOORE: I'm Ardela Moore. I work at Garnet Hospital in Middletown, New York. I'm an EVS worker. Essentially, my job is to clean up behind everything.

The discharging of the patients, the

COVID-19, it really impacted us.

We were the ones that suffered the most as far as the PPE, where we were the last ones on the totem pole. They didn't stock any of the PPE that we needed to take care of the cleaning and the daily needs of the nurses.

Any part of the hospital that needed to be cleaned, that was considered COVID. We needed everything, and it was a fight to get what we needed.

The hospital overlooked everything that we wanted to keep ourselves safe. They were worried about the nurses, the doctors, respiratory, you know, the higher-ups in our hospitals [inaudible].

It hurt a lot of us.

We questioned coming to work anymore, but then we remembered the patients need us. The hospital wouldn't function without EVS.

And it's just that we shouldn't have to fight for something that we know we need, and they know we need as well.

A lot of the members of my team have been out sick due to the COVID, contracted through work.

We all have families.

I'm scared to bring it home to my children.

Scared to give it to my mother, who is very sick, always in the hospital.

SENATOR RIVERA: If could you finish -- finish your thought, please, since your time has expired.

If you could finish your thought, ma'am, as you were saying.

ARDELA MOORE: Say that again?

SENATOR RIVERA: If you could finish -- finish your thought, as your time has expired.

Go ahead.

ARDELA MOORE: Yes.

But we just want them to know that EVS is a major part of the hospital, and hope they can get us the PPE we need for the next wave if it comes.

Thank you.

SENATOR RIVERA: Thank you so much, Ms. Moore.

Next, we will hear from David Vander de Carr, 1199 member, a respiratory therapist at Mount Sinai Morningside.

DAVID VAN de CARR: Good afternoon.

My name is David Van de Carr, and I'm a respiratory therapist at Morningside -- Mount Sinai Morningside Hospital in Manhattan.

I'm also the 1199 union delegate for my department.

I appreciate the opportunity to speak with you today and share my experiences during the pandemic.

COVID-19 presents most often as a respiratory illness, with shortness of breath and low oxygen levels in the blood, treated first with non-invasive ventilation; i.e., a BiPAP or a high-flow nasal cannula. Then sometimes a breathing tube and a ventilator. Often the disease manifests as a deadly pneumonia.

As a respiratory therapist, I have been at the front of the front lines at work, or, as I put it, I've been neck deep in COVID-19 for five months.

I have been with these patients from their arrival in the ER, through their complete course of treatment and recovery, and/or death.

Simply put, respiratory therapists help people breathe.

On a normal day at the hospital we might have 15 to 25 ventilated patients, with an equal or lesser number on non-invasive ventilation.

At the height of the pandemic we had 75 to 80 vents running every day, with an equal or

slightly lesser number of non-invasive.

At the same time, about 10 to 15 percent of my department was out sick with COVID.

So it was intense, it was relentless, overwhelming, and terrifying.

I also live in Jackson Heights, Queens, near Elmhurst Hospital, which is one of the hardest-hit areas of the city.

I'm happy to say that my family and I are so far healthy, at least physically, because myself and my team are still traumatized.

None of us will ever be the same, and we don't know if we can go through this again.

For months now, every little ache and pain makes me wonder if this is the day of the encounter with a patient that, you know, I bring it home, and I get sick, and I make my wife sick or my family sick.

I'm proud of the work my team did.

I'm proud of the nurses, doctors, and other specialists who joined me on the front lines every day.

I love my Morningside family.

I'm very proud of my union sisters and brothers who also joined me on the front lines every

day, who walked through the doors of that hospital and were right with us, neck deep, feeding, cleaning, transporting, supplying, and caring for all these people, and supporting the staff and patients in a hundred different ways.

I feel very good about the hospital's overall response.

Mount Sinai had to scramble for PPE, but they got it.

They got us help in the form of more ventilators and other equipment and additional staff.

Everybody had to think on their feet, and Sinai did a good job of that.

Where I'm disappointed in the hospital's response was with our "ancillary" staff and crisis pay.

The hospital did not do a good enough job supporting the ancillary staff with PPE, like Miss Arleda. Some of them got sick.

They are absolutely part of the overall care team and deserve to be treated as such. They have intimate patient contact.

I'm also disappointed in how the hospital handled crisis pay.

There are lots of ways to recognize the value of your people, and pay is one of the clearest.

Other first-class hospital systems in New York City stepped up voluntarily, establishing an industry standard.

The fact that we had to fight so hard with -- over this, the failure to meet the industry standard, and the mishandling of the payout, left a bad taste in our mouths about the hospital.

Again, I appreciate the opportunity to share my experiences during the pandemic.

I hope that we can use this time to be even better prepared for another possible surge.

Right now, my co-workers and I dread another surge; everybody that I work with.

We don't know if we can do it again, but it will make us feel better if we feel like we're better prepared.

Thank you.

SENATOR RIVERA: Thank you for that, Mr. Van de Carr.

And, next, we will hear from Judy Sheridan-Gonzales, president of the New York State Nurses Association.

JUDY SHERIDAN-GONZALEZ: Hello, and thank

you.

My name's Judy Sheridan-Gonzalez. I'm the president of NYSNA, where we represent over 40,000 nurses across the state. And, of course, our members were in the front lines in the fight against the pandemic.

I also live and work in The Bronx, and I have been an ER nurse in this unfortunate county for almost 40 years, right at the apex of the epicenter of this virus.

So our experience as front-line health workers, as caregivers, and patients, as rescuers and victims, offer a unique look at the serious weaknesses of our health-care infrastructure, its capabilities to manage disasters, and the systemic inadequacies that existed prior to the invasion of the COVID-19 virus.

These are the factors that exacerbated the deficiency of our response, and they have not been corrected.

I wanted to repeat that: They have not been corrected.

Should a surge occur, we won't be able to withstand it unless we fundamentally change the financing, administration, structure, and

functioning of our health-care delivery system, and the issues that drive the social determinants of health, as well, as an understanding that those of us who care for patients, who save their lives, cannot be left out of planning. That, was a fatal flaw; a fatal flaw that we saw time after time, and it continues.

The economic inequities that exist, and the profit-driven nature of our health care, has starved the system of resources essential to provide care for our patients.

This mantra of austerity versus fair taxation has resulted in underfunding public hospitals and safety-net facilities. These facilities were in the epicenter of the virus, with patients, mostly people of color, suffering and succumbing at a 2- or even 3-to-1 margin over other populations, including immigrants and the institutionalized.

Health-care cuts rendered all of our hospitals helpless to undertake the critical preparation essential to manage a pandemic, resulting in otherwise preventible deaths and severe complications.

I emphasize the word "preventible."

So these factors included:

Chronic understaffing and the absence of mandated ratios created such severe shortages that even a massive influx of volunteer and temporary staff could not meet our needs.

The absence of a standby critical care workforce resulted in ICU nurses forced to care for two and three times what is marginally acceptable, and a shifting of untrained staff to ICUs and medical units where ratios were also double and triple what was needed.

This resulted in deaths, complications, employee exhaustion, illness, serious illness, burnout, premature resignations, premature retirements, and ongoing PTSD among our staff.

We have not even been able to process that yet.

The lack of stored PPE, and the denial that this is, indeed, an airborne virus, and the absence of ventilation devices and medical equipment, and that's kind of like having no sandbags when you're waiting for a flood.

That was the situation we were in.

This led to illicit and ineffective use of protective equipment due to what is called "scarcity."

What was the result?

Worker deaths and illness at unprecedented proportions, and poor patient outcomes.

Hospital administrations' unwillingness to partner with direct caregivers to coordinate care, deployment, training, and logistics resulted in inefficient and dangerous operational errors, negative outcomes, worker infection, and unnecessary restructuring of operations.

Overcrowding, resulting from the closure of units, beds, and entire hospitals -- and I would point to Mount Vernon Hospital's pending destruction as a stark example -- made social distancing impossible, and they turned our ERs and other units into COVID petri dishes.

The loss of funds to hospitals due to cancellation of lucrative elective procedures exacerbated pre- and peri-COVID financial stresses, especially in safety-net facilities.

This created what we call a "COVID smokescreen" to justify dire cuts in ancillary staff and essential services, fulfilling a prior goal to save money, and dramatically increase efforts to shutter inpatient mental-health services with deleterious effects on those with mental illness,

their families, and communities.

And this is going on across the state.

So what will save our hospitals, health workers, and our patients, especially should a surge of COVID recur?

Involvement of front-line workers in all plans;

Implementation of minimum staffing ratios;

Reusable PPE procurement, such as elastomerics and PAPRS, reusable gowns, so we never again will even care about a shortage because we'll have everything ready to go;

A moratorium on closures, a reduction in services;

Immediate implementation of a program to guarantee equal access to quality care for all;

Fair distribution of hospital funding based on community needs and safety-net support;

Begin the transformation of health care into a system that removes profit as a driver, that is our dream, and our goal.

SENATOR RIVERA: Ms. Sheridan-Gonzalez, if you could finish your --

JUDY SHERIDAN-GONZALEZ: And that's last -- my last sentence.

SENATOR RIVERA: Okay.

JUDY SHERIDAN-GONZALEZ: And to generate the needed revenue -- this is probably the most important one -- to generated the needed revenue to rebuild the system with a fair taxation policy that will help everybody.

Thank you.

SENATOR RIVERA: Thank you, ma'am.

And we will have the Assembly leading us off.

ASSEMBLYMEMBER MCDONALD: Okay. Looks like we will start off with our health chair, Mr. Richard Gottfried.

ASSEMBLYMEMBER GOTTFRIED: [Inaudible.]

ASSEMBLYMEMBER MCDONALD: Who will unmute himself.

And while he's doing that, I'll recognize my colleague, Mr. Steve Otis, who also joined us.

Go ahead, Richard.

ASSEMBLYMEMBER GOTTFRIED: So, any of you can comment on this.

Our hospital trade associations, and, in our last hearings, the nursing home trade associations, have all been very enthusiastic in commending the administration/the executive branch for meeting with them frequently, and, in some cases, we heard daily,

to consult with what the needs of their institutions were, and about policies, and what should be changed, et cetera, et cetera, which was terrific.

What I've kept wondering is, are you aware of any kind of meeting schedules like that, for regular consultation with organizations representing workers, like your organizations, or with patients or their families?

JUDY SHERIDAN-GONZALEZ: Well, I can say that most of our units had to demand those meetings. They were not offered immediately.

Once the meetings took place, they were not meetings of collaboration. They weren't proactive.

Basically, we were told, this is what's happening.

We weren't given the data that we requested very often.

We still don't have the data of the number of deaths and illnesses of our own members and of patients.

And, the way in which it was managed was confrontational instead of collaborative, which is very unfortunate.

ASSEMBLYMEMBER GOTTFRIED: Interrupt for a second.

Are you talking about meetings with management of your facilities, or meetings with the health department or the Cuomo administration?

JUDY SHERIDAN-GONZALEZ: There were meetings with some of our leaders with the Cuomo administration.

But I -- again, the issue of listening to us, and, of course, and believing what we said, a significant issue is the absence of PPE and the issue of airborne respiration -- respirators -- airborne transmission of the virus.

Initially, hospitals had assured the governor that we had the equipment that we need.

The governor said we had the equipment that we need.

But we did not have the equipment we needed, and that was kind of a big battle to have to get into that.

We were having people reusing PPE, and using materials that were totally not scientifically sound, and, therefore, getting quite ill.

And the emergency room in which I work, I think, practically, 80 percent of our staff got sick.

ASSEMBLYMEMBER GOTTFRIED: So the sense of

close cooperation and consultation that the trade associations have discussed with us at these hearings, you never felt anything like that.

I wonder if 1199 wants to comment on that?

VERONICA TURNER-BIGGS: Absolutely, absolutely.

So while we had access to the administration, it certainly wasn't daily conversations.

And as Judy said, we -- in meeting with hospital administration, it was usually very confrontational.

It was [indiscernible] a confrontation about trying to ensure collaboration, and an understanding of the guidance and protocols.

So, yes, we had access to the administration, but not, I assure you, not at the same level as the trade associations.

ASSEMBLYMEMBER GOTTFRIED: Thank you.

Those are my questions.

SENATOR RIVERA: Thank you, Assemblymember.

Recognize Senator Tom O'Mara for 5 minutes.

SENATOR O'MARA: Thank you, Chairman.

Thank you all for participating in our hearing today, and your testimony, very important testimony, from the front lines.

And I want to thank each and every one of you, and the members of all your organizations, for the phenomenal work that has been done over the many months now that we've been dealing with this pandemic.

And, certainly, could not have handled it anywhere as close to as well as we have handled it without the dedicated workforce that we have there.

I have been, you know, asking questions throughout these hearings with regards to nursing homes, and particularly, patients being transferred to hospitals, and ultimately dying there.

I was wondering if, I guess, David, you're hands-on as a respiratory therapist there, if what anecdotal information you can provide about what you've seen as far as nursing home patients coming in, and ultimately not returning to the nursing home?

DAVID VAN de CARR: I mean, previous to the pandemic, there were a number of nursing homes in the area that we received patients from.

Our patient population is, mainly -- it's in Morningside Heights in Manhattan. It's mainly people of color.

So we would regularly receive patients from

nursing homes.

Especially if it's not a skilled nursing home, if there's not, you know, adequate medical care available to that patient, then -- and they certainly would send a COVID patient to the emergency room.

So we see that on a daily basis.

And that increased during the pandemic, there were more patients coming from nursing homes.

And, you know, when I moved to New York, one of my first jobs was in a nursing home, a skilled nursing facility, in Brooklyn, with a vent unit.

And my father-in-law got sick in Texas with COVID in a nursing home.

So we've seen an increase of patients, and, yes, some of them died. These are very ill people.

And the main health resource for the community that I serve is really the emergency room.

And -- so they end up, and a lot of them perished. You know, they have a lot of comorbidities. You know, kidney disease, there's heart disease, dementia, that make them more susceptible, as the nursing home population, and it is the population that we serve.

SENATOR O'MARA: How about the others on the

panel, any anecdotal information on that topic?

JUDY SHERIDAN-GONZALEZ: Yeah, I think the transport of very sick patients was a big problem, which is why we really need a cushion, in every hospital, of capable ICU staff, capable med-surg staff, and space and rooms for patients, because we received in the emergency room quite a few patients who were already dead, through the transport process, I don't know if, when they left? as soon as they arrived?

And these were infected patients that unnecessarily spread the infection, because, obviously, it's not a safe situation when you have somebody who is loaded with virus in an area.

But the transport was really serious.

We were kind of the nursing home central of The Bronx, Montefiore Medical Center. And so many of our patients did come from nursing homes.

Some returned, but they were very, very ill.

And, again, as I said, this transport issue became a nightmare for many of us because people really weren't safely transported.

And this is, again, it's so important for every single health-care facility to have enough space and enough staff to take care of people who

walk into our doors.

Our emergency rooms were already where people were packed like sardines, just -- where just people were on top of each other.

How do you avoid getting sick if you aren't sick?

So in the beginning it was horrific, it was a nightmare.

Eventually, we started to get control of the situation a bit, but it never should have happened that way. And we never want to see that again.

SENATOR O'MARA: Do you have any sense of what percentage of those patients coming from nursing homes did not survive?

JUDY SHERIDAN-GONZALEZ: I don't have access to that data, but I'm sure that we can get ahold of it.

OFF-CAMERA SPEAKER: Yeah, I don't have access to that data, either.

SENATOR O'MARA: Any other panel members wish to comment on that topic?

OFF-CAMERA SPEAKER: I don't have access to that data.

SENATOR O'MARA: No, the question before, the question before, just on the general influx of

nursing home patients to your hospitals?

VERONICA TURNER-BIGGS: So, yes, same as both David and Judy said, a number of patients.

[Indiscernible.] But, my peers who lead the nursing home long-term-care work consistently talked about the number of COVID-positive patients in nursing homes, and residents that didn't make it.

SENATOR RIVERA: Thank you, Senator.

SENATOR O'MARA: Time's up?

SENATOR RIVERA: Yeah, your time has expired.

SENATOR O'MARA: Thank you, Senator.

SENATOR RIVERA: Have a good one, man.

ASSEMBLYMEMBER MCDONALD: On the Assembly?

SENATOR RIVERA: Assembly, yes.

ASSEMBLYMEMBER MCDONALD: Yes, we have Assemblymember Dan Quart/Chair Quart.

ASSEMBLYMEMBER QUART: Thank you.

ASSEMBLYMEMBER MCDONALD: 5 minutes.

ASSEMBLYMEMBER QUART: Thank you.

And thank you to the panel for your very critically important and moving testimony.

I'm not sure -- to all the panel members who gave testimony, I'm not sure if you have weren't this morning.

I wanted to focus some of my questions in

relation to Dr. Zucker's testimony this morning, and, really, two specific parts: one about PPE, and another change in Chapter 117 of the reporting laws.

We'll start with Dr. Zucker's comments about PPE.

The nurses association filed lawsuit in April, setting forth in pretty detailed fashion, from firsthand testimony, and other sources, a lack of PPE equipment, specifically within hospitals, which runs contrary to Dr. Zucker's representation this morning that there was sufficient PPE within the hospitals.

And Dr. Zucker specifically said that not everything reported is accurate, I guess challenging the voracity of the information provided in that lawsuit and the front-line nurses and hospital personnel.

So, to all the panel members, if would you like to be able to respond to Dr. Zucker's representation, this is your opportunity to do so now.

JUDY SHERIDAN-GONZALEZ: So I can speak from personal experience.

When, initially, even prior to the terrible invasion of COVID that occurred after the first week

of March, and that escalated just exponentially, we tried to meet, to discuss the airborne nature of the disease, which the science really did provide.

And I have to blame the CDC for allowing the "scarcity" guidelines to give cart blanche to hospitals to say, well, we're following the CDC guidelines.

That was inexcusable, because we had enough opportunity to be able procure a proper PPE in advance.

Initially, we were even told in many of the hospitals: Don't wear masks. It makes the patients uncomfortable.

Then that got changed, we were allowed to wear masks.

Then they said: Don't wear N95s. You don't need them. It's not airborne.

In fact, in some of our facilities, nurses were disciplined for procuring their own N95s to protect themselves, when the hospital said that they didn't need them.

Then when it was obvious that people were dying, they allowed people to wear N95s, but then they were told: Wear them for a week. Put it in a plastic bag, put it in a paper bag, maybe it will be

re-sterilized.

That obviously did not work.

We had to fight, we had to even have social distance rallies, petitions, press coverage, to get the appropriate use of PPE, because there is something called "crisis contingency and standard use."

We should always be using standard use. We're not in a country that has no resources.

So that is not true.

Getting scrubs, getting gowns, getting appropriate gowns, getting non-permeable gowns, and, shields, getting shields that didn't fall apart.

We didn't have the appropriate PPE.

That's why we came to the conclusion that we needed reusable PPE.

Number one: It doesn't contaminate the environment with all the waste of disposables;

And, number two: It's something that allows you to not have a shortage.

If you have the elastomeric or PAPR, which you can again, it's a personal device, it's not even that expensive. The elastomeric is about the price of what it costs to wear N95s for two months. It doesn't scar your face permanently.

I don't know if any of you have seen what's happened to some of our staff, with the permanent scars and abrasions all over their faces, and breathing in their own carbon dioxide, passing out, fainting. And, also, the removal and putting back on allows more contamination.

So our big struggle now is to procure these reusable devices.

Several hospitals in Brooklyn have taken that step. We are so proud of Brooklyn Hospital and One Brooklyn Health for doing so.

But, initially, it was a nightmare.

Eventually, after having to be out in the streets, and engage in all kinds of confrontational activities, we did get PPE. But, we don't feel confident that there's enough for us.

And we think that now is the time to start procuring the disposable items that will save our patients and save our staff.

Nobody should have died taking care of these patients, and many did.

ASSEMBLYMEMBER QUART: Thank you.

I have about -- thank you for your comments.

Just one last question, since I have about 45 seconds left.

We talked about, this legislature, and signed by the governor, amended Chapter 117 of the laws of 2020. But, actually, the original law goes back to 2002, and it's all about reporting; about avenues open to hospital front-line workers to make complaints about situations that are deficient within hospitals.

We changed the law to add another way in which to complain about, quote/quote, improper quality of workplace safety.

But the form in which to make those complaints existed as of March of this year. We just added on to that.

My question is, to all those on the panel: Whether you feel comfortable about any sort of communication avenue between yourselves, your hospitals, and DOH, to levy complaints about improper quality of care within the hospital.

SENATOR RIVERA: If anybody has a quick answer to that, since his time has expired.

VERONICA TURNER-BIGGS: David? Ardela?

DAVID VAN de CARR: Yeah, I mean, I didn't -- I've frankly been so busy during the whole thing, I didn't -- I mean, I didn't see anything glaring in my experience, you know.

SENATOR RIVERA: Got you.

All right, thank you, sir.

Thank you, Assemblymember.

Move on to the Senate, recognizing Senator Skoufis for 5 minutes.

SENATOR SKOUFIS: Thanks very much.

And as many of my colleagues have already said, I want to thank all of you on the panel for testifying, and, more importantly, for everything that you've done these past many months during COVID.

My question, I want to ask all of you:

I can't even begin to imagine the emotional, psychological, toll that these past five months have been to all of you; your members, your colleagues, in hospitals.

And I'd like you to speak to, if you can, what, if any, services were made available by your employers, the hospitals, to try and take care of these needs that, you know, I think, quite frankly, weren't front and center for folks in government, for folks in the industry, but are incredibly important?

Were any programs set up, or any psychologists hired, mental-health professionals,

made available to all of you?

I imagine it's similar to PTSD during war time when people are serving overseas. Right?

Can you speak to some of that?

DAVID VAN de CARR: We had -- my department had several meetings with a sort of grief counselor.

And a kind of therapist who was made available to myself and some nurses for like a Zoom call that happened.

I know I was on it once.

And I think they -- you know, I think Sinai did provide some of that help.

SENATOR SKOUFIS: Do you think it was adequate, what they did?

DAVID VAN de CARR: I've been through therapy before.

I mean -- I mean, we all need a ton of help with this.

And, you know, it's kind of -- I get a lot of my therapy from the people I work with, you know, talking about it, because they're the ones that understand what happened.

So --

VERONICA TURNER-BIGGS: I would add --

DAVID VAN de CARR: [Indiscernible

cross-talking] --

VERONICA TURNER-BIGGS: I'm sorry. I'm sorry, David.

I would add that a number of the health systems and institutions provided some minimal level of programs.

The issue is, that this -- it's very traumatic, and there will be lasting trauma, and so it has to be ongoing work that is done.

At 1199, through our benefit fund, we have ongoing therapy, or programs, for folks -- for our members.

And so, yeah, I think we just have to be very thoughtful, that this is -- you know, this is -- the trauma is real, and a few sessions are not going to get people through what they experienced.

JUDY SHERIDAN-GONZALEZ: Yeah, I totally agree with what was said previously.

Our union also developed an assistance program. And several social workers in the community offered their services for free.

I think we got most of our support from each other, as David said, and from our community.

The people who brought us food, and who clapped, and just created an environment of love and

support, was really helpful during the time.

As I said, we haven't really processed, we're still kind of in it.

So I think the ongoing effects are definitely going to be very dramatic.

Some people were traumatized just because of the virus itself, and the outcome, and the problems.

But I think prevention is -- I mean, you can provide therapy. But when you can also provide staff that you need, and you're not doing it; when you can provide the equipment that you need; the space that you need; the training that you need; all the things that would have eased some of that pain of trauma, of having people die because they say: Well, don't go in the room, you're not really protected. Don't spend time with the patient. Don't stay in the room.

If you don't stay in the room, the patient doesn't survive.

So we had that, as professionals, not being able to give what we could give.

Being with a patient is what nurses do to save lives.

Being told, don't go in the room, don't stay

in the room, of course we're not protected.

Protect us so we can do that.

The prevention would have alleviated some of the trauma.

But certainly, without, this disease has created trauma for everybody.

And nobody is going to survive as a caregiver if we have to go through it again.

That's why prevention and preparation and planning and participation are all critical.

VERONICA TURNER-BIGGS: I agree, I agree.

And I would just add that, for ancillary staff, who, every single day, had to fight to ensure that they had the adequate PPE, the relationship and the trauma that they are experiencing because they lost co-workers is very, very real.

SENATOR SKOUFIS: Thanks for your answers.

SENATOR RIVERA: Thank you, Ms. Turner-Biggs.

Thank you, Senator.

Assembly.

ASSEMBLYMEMBER MCDONALD: In the Assembly we will recognize myself for 5 minutes.

I want to thank all of you, not only -- and all of your members, for not only on the front lines, but your testimony today. It's very

meaningful, and it's sincerely appreciated.

Veronica, in your beginning, it really caught my attention, and, of course, I'm an upstate guy who hasn't really -- doesn't know the ins and outs of the downstate hospital system.

So I'm going to put that out front. All right?

But what concerned me about this hierarchy of distribution of masks -- and we probably don't have enough time to get into this today -- I'm very interested, though, in some supporting information, because I think that -- that's bothersome to me.

I know -- I'm a practicing pharmacist.

I know when hydroxychloroquine was the new thing, all of a sudden, doctors I've never seen before were looking for hydroxychloroquine. And they were using their privileges to do so, and that's not fair at the end of the day.

All people on the front line need to be treated fairly and equitably.

So this was really happening in your operation?

VERONICA TURNER-BIGGS: Absolutely, absolutely.

As you heard Ardela's testimony, like,

initially, EVS workers, who had to go in and clean the rooms, were told that they were okay to wear surgical masks.

Unit clerks who were on COVID-positive units were told that it was okay to wear a surgical mask.

The folks that register you when you come in through the ER were told that it was okay to wear surgical masks.

It was very real.

Transporters, transporting COVID patients, were told it was okay to wear surgical masks.

ASSEMBLYMEMBER MCDONALD: Okay, but, individuals that were caring for patients were told they couldn't? Is that what you're telling me?

VERONICA TURNER-BIGGS: Yes.

Bedside clinicians were given, for the most part, adequate PPE.

Although, as Judy said, initially, they were told that they could wear the PPE if it wasn't soiled, for seven days, the masks, the N95.

ASSEMBLYMEMBER MCDONALD: I remember Judy's testimony well.

Well, that seems to me a little bit backwards, if you ask me.

No disrespect to -- I mean, everybody should

be treated fairly at the end of the day.

I would appreciate, after, if we could have some more follow-up about this, because that just strikes me as unfair.

VERONICA TURNER-BIGGS: Absolutely.

ASSEMBLYMEMBER MCDONALD: The other thing, the whole Manhattan Hospital versus the other -- I don't want to get into a borough warfare down there -- but, is that a function of -- you know -- I mean, I'll be honest with you, I'm a health-care provider too, it was a hustle to try to get supplies.

Do you think that was more, that they had the resources, or they had the right people doing procurement, or it was just a matter of luck?

Or -- because you probably have members in -- I imagine, all your organizations have members in all the different boroughs.

Where -- what is the underlying issue there?

VERONICA TURNER-BIGGS: So, in my opinion, I think it was absolutely related to the resources; having the resources to compete in the private market.

ASSEMBLYMEMBER MCDONALD: Uh-huh.

Thank you.

And, David, your testimony about crisis pay, and you mentioned that other systems seemed not to have a problem doing this.

And I wasn't clear if somebody -- if there was eventually some crisis pay paid. Or --

DAVID VAN de CARR: There was.

ASSEMBLYMEMBER MCDONALD: -- oh, there was some.

Okay, but it was more --

DAVID VAN de CARR: It was --

VERONICA TURNER-BIGGS: After a fight.

DAVID VAN de CARR: -- NYU, Montefiore, Columbia, all gave their 1199 members.

It was voluntary, completely voluntary, by Sinai and all the other hospital systems.

We were -- we're under a contract that goes till 2021.

So they all -- all these hospital systems, you know, came to our members and said, and the industry standard was, NYU is a little higher, about $2500.

Sinai did a -- sort of a complex weekly bonus, which then tied into overtime, which was advantageous to the hospital because, for most five-day-a-week workers, when they work their sixth

day, that $100 a week that they got for a day shift was -- their overtime was calculated upon.

It was a very complex thing.

And what ended up happening was, we got this -- I mean, straight up, maybe 1500; $1,000 thousand cash, which was -- we were given an ultimatum [indiscernible].

ASSEMBLYMEMBER MCDONALD: I don't want to cut you short, because I do want to follow up with this, so we can follow up after this.

But I guess the question that needs to be asked, which maybe you don't have the answer, because we talked to the hospital associations earlier:

I wonder, I'm just wondering out loud, if there was a correlation between the amount of money they were getting from the feds, that could be actually transported.

You know, obviously, the money was provided to providers, to share with their staff.

Now, if it was shared unfairly, we need to investigate that further.

VERONICA TURNER-BIGGS: We certainly --

ASSEMBLYMEMBER MCDONALD: Thank you.

VERONICA TURNER-BIGGS: I'm sorry.

We certainly made the argument, when we demanded to have discussions with some of our institutions around hazard pay for health-care workers.

We absolutely referred to the money that they received from the feds, in a way -- a potential way for them to apply hazard pay for folks.

SENATOR RIVERA: Thank you.

ASSEMBLYMEMBER MCDONALD: Thank you very much.

SENATOR RIVERA: I'll recognize myself for 5 minutes.

Judy, I want to follow up with, when you were talking about nurses being disciplined for wearing N95 masks.

If I understand correctly, what you said was, that there were situations in which some of the nurses that you folks represent brought their own equipment, and they were penalized for doing so?

JUDY SHERIDAN-GONZALEZ: In some facilities they were told they couldn't do it. And some facilities there were memos that sent out, that had a vague reference, that was very clear, that what they said, "inappropriate use of N95s could lead to termination."

Meaning, they were still locked into that, it's not an airborne virus.

And if you're not involved in aerosolized procedures --

Which, you know, we can talk about later what those are. You know, to me a sneeze is an aerosolized procedure.

-- you know, people would be disciplined.

We had to go to the press.

Every time, to defend people, we had to go to the press, go to you, go to others, to put pressure on the facilities to deal with that.

So when we found out about stuff in advance, we were able to stop it. But in some facilities people were told, if they didn't take off their own equipment, they would have to go home, and things like that.

SENATOR RIVERA: So in your experience, did you find that there -- before --

Because, obviously, what led you to go public is that you wanted to make sure that those things didn't happen.

-- were there members of your union that were -- that for -- that -- where disciplinary actions were taken against them?

JUDY SHERIDAN-GONZALEZ: I think that those were initiated, but we were able to deal with every issue that I know about.

But there, sometimes, members don't come to us and we don't know even what happens to them.

In every instance in which we were aware, we intervened to defend the member.

And I think, as the science became much clearer, the hospitals were sort of like had their tails between their legs.

SENATOR RIVERA: But in your experience, whenever -- whenever it was brought to their attention, it was rescinded --

JUDY SHERIDAN-GONZALEZ: Yeah --

SENATOR RIVERA: -- the disciplinary action?

JUDY SHERIDAN-GONZALEZ: -- and -- insofar as I know.

I don't know about every situation throughout the state, but the area -- that what I'm aware of, we were able to stop it.

But people were wearing -- many people brought their own stuff from home because they were just very -- I know a nurse -- I know several nurses that paid almost $1,000 for their own PPE because they were so unsafe.

SENATOR RIVERA: Miss Turner-Biggs, do you -- did any of your members have experiences similar to this, as far as disciplinary action for bringing on their own equipment?

VERONICA TURNER-BIGGS: Absolutely.

Absolutely, we had members who had to don trash bags because they did not have the gowns, working in nursing homes attached to hospitals.

We had members who were told that they did not need to wear N95s, and who insisted on wearing N95s, because they had direct patient-care responsibilities as well, and who were threatened with discipline.

SENATOR RIVERA: Now, there were instances where -- that we have heard -- there were -- there were instances that we know of, where some workers said, we were not getting the equipment that we needed. But the hospital was not telling the State that they needed -- you know, that they needed equipment.

I'm sure that you're aware of that going back-and-forth.

We asked the department of health, as well as the hospitals, and they said, no, if they needed something, they should have asked us. And when we

asked them whether they needed it, they said they didn't.

So there was obviously a disconnect somewhere there.

And although some of it, I'll -- you know, again, we give everyone the benefit of the doubt in this type of very serious crisis, that in a time of triage there might have been a lack of communication.

My question to you is: Do you believe that there might be a way -- is there a way that you believe that, maybe legislatively, we could address this type of -- this type of situation as it relates to disciplining members?

Because, for example, I remember that there was a situation where it was a personal friend. I managed to get my hand on a -- on a -- like five N95 masks. And he's an ICU nurse.

And I said I was going to give them to him, because I could use other ones.

And he was, like, I can't -- I can't take them because I can't use them.

And I was, like, I don't -- that makes no sense to me if you're, like -- he's an ICU nurse.

So -- but my question is: Do you believe

that there's something that, legislatively, we could, potentially, to be able to deal with this?

VERONICA TURNER-BIGGS: So I would say, yeah, folks ought to be protected for advocating on their own behalf.

There was so much, early on, that folks didn't know, and there was high anxiety, and folks wanting to ensure that they had the adequate PPE.

And remember, the guidance was changing every single day. And hospital protocols were changing every single day.

So just as soon as our members understood the day-before guidance and protocol, the very next day, or the very next week, the guidance and protocols would change.

And so I do believe that there is something that should be done.

I am not sure on what it is, but I don't believe that people should be disciplined for advocating that they keep themselves safe, their co-workers safe, and their families safe --

SENATOR RIVERA: Thank you.

VERONICA TURNER-BIGGS: -- while caring for patients.

Thank you.

SENATOR RIVERA: Thank you, ma'am.

Assembly.

ASSEMBLYMEMBER MCDONALD: [Inaudible.]

SENATOR RIVERA: Chair McDonald, we can't hear you.

ASSEMBLYMEMBER MCDONALD: I know. I hear you.

We will now hear from our ranker, Kevin Byrne.

ASSEMBLYMEMBER BYRNE: Thank you.

And allow me to echo what my colleagues have already said, to thank each and every one of you and the members that you represent.

We need more of you, a lot more of you, and a lot more of your members, in this state.

I wanted to follow up on the some of the comments and questions that were asked by my colleagues earlier.

Certainly, I know this was -- this pandemic has stressed our health-care system tremendously, especially during the peaks.

And, Judy, you mentioned Montefiore.

And I know there was a -- even a -- I believe it was a CBS Special, that highlighted the high pressures at the hospital in The Bronx.

And, David, I believe you talked about some of the challenges as well, and Veronica.

One thing that I think maybe David may have even said it, or Judy, people putting in retirement early.

And that struck a little bit of a nerve with me, just because two women that I care about most in this world, obviously, my mother and my wife, and both of them work in health care.

My mom's a respiratory therapist, but she just retired. And she ended up retiring in the middle of this, two weeks before my child's due date. That way, she could actually hold my newborn son when there was time.

And I don't feel like that's something most people have to, you know, think about when they're retiring. It's a frightening situation.

But I wanted to ask about the mental health and stressors that are on your members.

Senator Skoufis/Chairman Skoufis talked about what programming is available, and I think he made a comparison about our military. And I think that was -- that made sense.

We do have peer-to-peer programming for veterans, peer-to-peer supported by the State.

I believe the New York Shields has something similar, or did at least, called "Cops to Cops." So there are similar programs for first responders.

Is that something you think would be helpful or beneficial as well for health-care workers, and would it require more State support?

DAVID VAN de CARR: I do believe -- yeah, I do believe that. And any State support for that would be welcome.

And I did one Zoom call with a nurse that I know from the ICU, and this therapist from Sinai. And, I mean, after the call, it was, like, you know, I can just talk to Beth at work in the ICU.

And I appreciate the woman's efforts, but she's been at home on Zoom for that whole time.

And, you know, I commend your wife, sir, for being a respiratory therapist.

ASSEMBLYMEMBER BYRNE: That's my mom.

My wife's a PA.

DAVID VAN de CARR: Oh.

ASSEMBLYMEMBER BYRNE: But my mother was a respiratory therapist.

DAVID VAN de CARR: Oh.

ASSEMBLYMEMBER BYRNE: And, David, I want to follow up, just because I don't have so much time:

Just, anecdotally, from people I know that work in the field, you know, the -- obviously, very stressful time for respiratory therapists.

I believe you're one of the most, if not top three, top two, most exposed profession with this virus.

I think it's dentists and respiratory therapists are at the top.

With the use of ventilators, and we heard the commissioner talk about that, in New York, every patient that needed a ventilator got one.

Was that something that you -- in your experience, that you could confirm as well? Or was it, at times, really cleaning a ventilator and putting it onto the other patient?

Because I've heard different stories anecdotally.

DAVID VAN de CARR: We -- at Morningside every patient that needed a ventilator got a ventilator. Maybe not the type of ventilator that the doctors wanted.

We had a lot of what are called "LTV ventilators," which are used for transport, really, from the, I think, Homeland Security, or something. A disaster prepare -- FEMA, maybe, that we got for a while.

And I got to say, Sinai really stepped up and really got us the equipment.

But there was still, you know, a shortage of the preferred-up name ventilator, the Maquet Servo I, and the circuits for those ventilators; circuits for the high-flow nasal cannulas; different therapies, nitric oxide, VELETRI -- inhaled VELETRI.

Yeah, we were struggling.

You know, I mean, I'd have a patient, a doctor come to me in the ICU with a used high-flow nasal cannula which has just been on a patient, aerosolizing, you know, COVID all over the room.

He brings me, "I want this on this patient. Here it is."

And I can't just put it on that next patient, you know.

But, yeah, overall, they really -- at my hospital they really came through.

They shuffled ventilators between, you know, Mount Sinai Main and West. And -- and, you know, they didn't always get the ventilator they wanted, but -- and they purchased a lot of equipment as well.

ASSEMBLYMEMBER BYRNE: That's encouraging.

Thank you, sir.

I know I'm out of time.

Thank you, Senator.

SENATOR RIVERA: Thank you, Assemblymember.

Currently, no member of the Senate to ask questions.

Back to the Assembly.

ASSEMBLYMEMBER MCDONALD: Back to the Assembly, we will have Member Tom Abinanti.

ASSEMBLYMEMBER ABINATI: There we go.

Thank you all for joining us today.

And I want to join my colleagues in expressing a real gratitude for the work that you and all of your fellow front-liners have done.

You really were very important.

I want to go to a different topic that I've been asking everyone about.

I have a lot of concerns about the policy that the State imposed, restricting visitors, what we call "visitors," to patients.

In many cases, the, quote, visitors were parents of children with disabilities who could not speak for themselves, or they were staff from a -- let's say a group home with those children.

Then you had some senior citizens who came in

who really needed additional care.

Do any of you have any comments on what the policy was in the beginning, what it became, and what it is today?

Are the parents, are the visitors, in the way? Are they helpful?

And what is the policy today?

What do -- how do you guys react to it?

What do you think the policy should be?

I just want your thoughts on that.

Maybe we start with Judy?

JUDY SHERIDAN-GONZALEZ: Yeah, I mean, I can say there's -- pre-COVID, there was a variety of visitor policies that existed in all the facilities, because there were always problems with visitors that could have been mitigated by, I think, ombudsmen -- ombudspersons, in general, that would have really been helpful.

The hospitals used to have translators, ombudspersons, other people, to support visitors and family members and caregivers of patients when things became difficult.

With the crowding that exists, particularly in our underserved communities, the visitor issue becomes unfortunate and unnecessary trauma for

everybody, because people have the right to be with family members. And I'm talking about pre-COVID.

But when it's so crowded and so dangerous, even without COVID, then you have to figure out, what are you going to do?

Again, prevention is -- what, an ounce of prevention is worth a pound of cure.

I think creating facilities that are safe enhances visitor participation.

During COVID, I think in the beginning it was just very scary.

The testing wasn't there.

If testing had been there, I think the visitor policy could have been adjusted.

But there wasn't testing, there wasn't tracing.

So much was unclear. The restriction of visitors probably was necessary at that point.

But once there was a handle on it, and I know with pediatrics, there was one caregiver was permitted, as far as I know, in most of the facilities.

But it was a touch-and-go situation.

I think that if we had additional staff to work with family members and visitors, that would

have alleviated a lot of the trauma that families went through. And I think that it probably could have been addressed a lot better.

But it was a very touchy situation in the beginning because the transmission of infection just couldn't be -- it had to be addressed; we couldn't allow it to happen.

SENATOR RIVERA: Thank you, Judy.

Thank you, Assemblymember.

Still nobody in the Senate.

Back to the Assembly.

ASSEMBLYMEMBER MCDONALD: Back to the Assembly.

And with that, we will go to Ranker Brian Manktelow.

ASSEMBLYMEMBER MANKTELOW: Yes, thank you, Chairman.

Judy, just a couple of questions for you.

First of all, and for all of you, thank you so much for your commitment to the people you deal with every day, and for being on that front line.

Much appreciated.

Judy, is there a lack of nurses right now that you see?

JUDY SHERIDAN-GONZALEZ: Working in the

facilities, absolutely.

I think there are nurses that aren't working in facilities that exist, but they're not hired.

ASSEMBLYMEMBER MANKTELOW: What can we do to make that happen?

JUDY SHERIDAN-GONZALEZ: Well, I think if we had minimum staffing ratios, they would be forced to hire.

We now have a situation, although census is low, in our emergency department, the census is rising.

In my own hospital, they're not allowing people to work overtime or bring in per diem nurses to cover.

So we're back to the situation of nurses taking care of 10 and 12 patients at a time, or 6 or 7 critical-care patients.

So I think that we need to have standards.

Ratios are the best standards because they ebb and flow with ebb and flow of patients.

It's not like you have to have 1,000 nurses. You have to have one nurse for every four patients, or one nurse for every five patients.

So there gives the hospitals the flexibility that they say that they require, but it ensures that

every patient gets the care that they need, and every nurse is used to the best of his or her ability.

But, definitely, there are nurses that are looking for jobs, that want to have jobs. There have been nurses laid off.

And I would also include, there's an incredible amount of ancillary staff.

We work in a health-care team, not just about registered nurses.

It's about LPNs, it's about respiratory therapists, it's about nurses aides; we all work as a team. And cutting one piece of that team, there's harm done to the other piece of that team.

So all of the staff that is needed should be there, and those cuts have been deadly, which is why cuts -- cuts kill.

VERONICA TURNER-BIGGS: I appreciate you adding that, Judy.

ASSEMBLYMEMBER MANKTELOW: So -- anybody:

So the cuts, that's really what is hurting you.

Is it totally financial, or is it -- why are there the cuts?

VERONICA TURNER-BIGGS: I'm very concerned

that there's going to be additional cuts.

I believe in the earlier panel --

Oh, gee -- oh, sorry.

ASSEMBLYMEMBER MANKTELOW: You're good.

ASSEMBLYMEMBER BYRNE: -- in the earlier panel, Ken Raske talked about there needing to be additional cuts.

I'm concerned that those cuts will be on the backs of workers; it will be workers that are the cost that get cut after they just were on the front line in this pandemic.

And I know that many of our institutions are talking about either the voluntary severance packages, early-retirement incentives, or, layoffs, they're going to be faced with layoffs.

So I am very concerned about being prepared for a second wave.

ASSEMBLYMEMBER MANKTELOW: Is everyone on the panel hearing layoffs? Is that what we're hearing?

JUDY SHERIDAN-GONZALEZ: Yeah, it's out there.

I just want to add one other thing, this question of trauma.

You know, many of us still haven't processed the trauma. You know, we're not ourselves, we're

not normal.

And we're -- and, in addition to the staff cuts and the other pressures on us, hospitals now are kind of now laying the blame on us.

If we can't get certain things done, even though we don't have enough staff, even though we're not ourselves, even though we're traumatized, we're seeing a huge rise in employee discipline, based on simple things. Documentation omissions, things like this.

The hospitals are being very punitive right now.

And I think more people are going to leave the profession after they process what they've been through and the way they're being treated.

And we're seeing this as a trend that is very, very dangerous and very damaging, and incredibly disrespectful to people who have given their health and their lives to their communities.

This -- I don't -- I believe it's happening across the board.

ASSEMBLYMEMBER MANKTELOW: Yeah, I -- just like in life, you know, money seems to be an issue all the time. When the money's short, things happen, unfortunately.

But, Judy, earlier on you had said something about a fair taxation policy.

Could you share a little bit of that with me?

JUDY SHERIDAN-GONZALEZ: Yeah, there's several taxes that have been put forward: the pied-á-terre tax, the billionaire tax, the stock-transfer tax.

And like I say, some of these bil -- there's 118 billionaires. They won't even lose a swimming pool when -- if they pay their fair share of taxes.

And some of them, there's a group called "Patriotic Millionaires." They're saying, Tax us more.

The money is out there.

These are taxes that existed years ago, that we had no deficit when we had those taxes.

Many of us in the community, in the workforce, feel that we have paid our fair share of taxes. But, meanwhile, Jeff Bezos and all these multi-millionaires and -billionaires have made money out of the pandemic.

It's just an outrage.

We shouldn't have people starving. We shouldn't have people being evicted. We shouldn't have people denied health care. We shouldn't have

people have to go into debt.

These are things that are wrong.

We should have enough staff to take care our community.

What good is government if it can't protect and care for its people?

And that's what taxation is supposed to do.

So, absolutely, we're talking about taxes that do not affect the middle class, do not affect even the upper-middle class.

We're talking about the very richest of people.

ASSEMBLYMEMBER MANKTELOW: All right.

Thank you so much.

And thank you everyone for being on the panel today.

SENATOR RIVERA: Thank you, Assemblymember.

Still back to you folks. Nobody on our side.

ASSEMBLYMEMBER MCDONALD: Thank you very much.

We will now go to Missy Miller for 3 minutes.

ASSEMBLYMEMBER MILLER: [Inaudible.]

Sorry.

Thank you so much for being here, and for everything that you have gone through, and have done

for everybody. We sincerely thank you.

I hear all of these problems, and I'm just curious, from a legislative perspective, how can we help, moving forward?

And what can we help to do if there is a second wave?

What -- what, you know, honestly, realistically, can be done?

JUDY SHERIDAN-GONZALEZ: I mean, I think passing legislation to get more revenue is critical, even without a surge, but absolutely will be essential if there's a surge.

I think passing legislation that really examines the different way of financing health care, because the issue of profit driving health care is a problem.

It is not profitable to have storages of masks and equipment.

It is not profitable to have people, especially trained, where you don't need them for the moment.

It's not profitable to have a hospital open when it's costing you money, quote/unquote.

Health care should be a public good -- treated like a public good, and everybody should be

able to have it.

We need the revenue there to be able to make that happen, and we need the health-care system to be structured in such a way that profit is not an issue.

It's health care; it's about the people, it's about everyone. Every single human being having the right to quality health care, not just people who can afford it or who happen to have the right insurance.

So I think that those are definitely some things.

And also having ratios or staffing numbers put into place that ensure that every hospital and every facility has enough staff to take care of the patients to give them what they need.

ASSEMBLYMEMBER MILLER: Do you [indiscernible cross-talking] --

JUDY SHERIDAN-GONZALEZ: Those are [indiscernible cross-talking] --

VERONICA TURNER-BIGGS: I'm sorry. I was just [indiscernible cross-talking] --

ASSEMBLYMEMBER MILLER: Do you think this -- this catastrophe that unfolded was the result of not enough funding?

VERONICA TURNER-BIGGS: I think --

JUDY SHERIDAN-GONZALEZ: [Indiscernible cross-talking] -- I don't know if Veronica wants to answer.

I mean, I think it's not enough funding in the way hospitals -- the health care is structured.

As I said, being driven by profit does not give you a good public health-care infrastructure, when you look at other countries who at least had some stuff in place to be able to take care of people, even though we all suffered from the virus.

But the structure of health care driven by profits is not conducive to dealing with a disaster where you need preparation, you need materials, you need planning; you need things in place that don't generate money. And you need to take care of people that don't have money.

VERONICA TURNER-BIGGS: That part.

ASSEMBLYMEMBER MILLER: Is that what you were going to say, Veronica?

VERONICA TURNER-BIGGS: Very similar.

Very similar.

We have to take advantage of this time now to prepare for the second wave, and that means learning from the best practices, and ensuring that we're

coordinating the purchases -- the purchasing of adequate PPE.

I don't think ever again that we should tolerate an institution not having what they need, and health-care workers not having what they need.

ASSEMBLYMEMBER MILLER: Thank you.

SENATOR RIVERA: Thank you, Assemblymember. Back to you folks.

ASSEMBLYMEMBER MCDONALD: And last, but not least, for 3 minutes, Ron Kim.

ASSEMBLYMEMBER KIM: Thank you, Chair McDonald.

So, earlier today Senator Skoufis talked about the need for mental health in dealing with some of the trauma among our workers.

I had a -- I just -- I had a very small glimpse of what the workers were going through in April when I was visiting these facilities.

I mean, I had workers crying because of the stress.

And, you know, I just -- just seeing even a small glimpse, I can't imagine what you're processing now.

So I just want to lend my support for Senator Skoufis and others that want to make sure

that we have enough resources to take care of our mental health of our workers, moving forward.

You know, we have these associations, the management, and everyone else, you know, putting up thank-you signs, and the governor wants to do a parade for you all, and celebrate all the heroic work.

Do you want a parade or you want to get paid?

VERONICA TURNER-BIGGS: Our members want to be paid.

ASSEMBLYMEMBER KIM: Okay. That's what I thought.

VERONICA TURNER-BIGGS: We absolutely appreciate the Friday evenings, gatherings and hand-clappings. But our members want to be paid.

Again, our members used their own money, staying in hotels, catching cabs to and from work, so that they can ensure that their families were safe.

Yeah, our members want to be paid.

ASSEMBLYMEMBER KIM: Okay.

And, Judy, you know, you mentioned about, and I think this is very important, that a lot of workers were infected doing transporting and arranging for care of COVID patients.

And I asked the commissioner earlier, whether we should be investigating this, some of the bad practices, the last few months, because workers and the patients deserve justice.

His response was that, we're still in the middle of the pandemic, and we can't -- we don't have time to go back and investigate those cases.

Do you think we need to get this right, moving forward, and try to figure out, for the workers who did get infected, who were impacted, and the families were impacted, to go back and try to seek retroactive justice for all those impacted workers?

JUDY SHERIDAN-GONZALEZ: I mean, we still have health workers that have to fight to get workers' compensation.

You know, we were told initially that, well, if you -- you know, my hospital CEO went on record as saying, Well, we know, it's clear, that 82 percent of our workers got COVID in the community.

Like, that's outrageous.

You know, we got it because we were exposed to people and we weren't protected.

We got it because some of us did have

comorbidities and weren't given an alternative and a place to work.

I don't just mean in my hospital. I mean across the state.

People were afraid they would lose their jobs if they wouldn't, you know, care for COVID patients, even though they were immunosuppressed, or pregnant.

We had a lot of issues surrounding that.

Or lactating.

All the kinds of issues that occurred.

So I think that, you know, people -- investigation should be always happening, research should always be going on.

Ask people what they think, ask people what they need.

But this question of being denied workers' compensation, because you have to prove, I caught COVID on Tuesday from this patient at that moment.

Really?

That's an outrage.

People should be able to be cared for.

We don't know the long-terms effects of this illness. And people could have said, I'm not working anymore. I'm not coming to work.

And they had the right to do that.

I absolutely support that right.

But there were people that went to work anyway, and were in danger.

They need to be supported.

SENATOR RIVERA: Thank you, ma'am.

Thank you, Assemblymember.

I believe that we're done on that side?

All right.

Thank you everyone who was part of this panel.

Have a great rest of your afternoon.

Moving on to Panel Number 5, we're joined by:

Elisabeth Benjamin, vice president of Health Initiatives of the Community Service Society of New York;

Anthony Feliciano, director of the Commission of the Public's Health System;

Judy Wessler, a resident of New York, and a legendary health-care expert;

And, Lois Uttley, women's health program director for Community Catalyst, and coordinator for Community Voices for Health System Accountability.

ASSEMBLYMEMBER GOTTFRIED: [Inaudible.]

SENATOR RIVERA: We can't hear you,

Gottfried.

Let's see if they're going to be coming in in a second.

ASSEMBLYMEMBER GOTTFRIED: Okay. Sorry.

Do each of you swear or affirm that the testimony you're about to give is true?

ELISABETH BENJAMIN: Yes.

LOIS UTTLEY: Yes.

SENATOR RIVERA: Okay.

ASSEMBLYMEMBER GOTTFRIED: Okay.

SENATOR RIVERA: Are the rest of the folks -- okay.

Are the rest of the folks coming on?

While that happens, go ahead, Ms. Benjamin.

You may begin.

ELISABETH BENJAMIN: Go ahead, who? Me?

SENATOR RIVERA: Yes.

ELISABETH BENJAMIN: Okay. Sorry.

It's a little hard to hear, so, I'll do my best.

Thank you all very much for having this really important hearing today on COVID and New York State's hospitals.

I work at the Community Services Society. We're a 175-year-old non-profit. We serve --

I mean, we try to bring the voices of low-income and vulnerable New Yorkers to the policy conversation.

In addition, I run the health department that serves around 130,000 New Yorkers, finding insurance, addressing medical debt, and dealing with insurance problems.

I want to start out my comments today by thanking and commending the workers at hospitals who have, you know, so tirelessly, as we just heard, you know, sacrificed on behalf of us all.

And it is extremely moving to be able to speak after them and be able to applaud them.

I wish they were still on to hear my applause.

And I do think they should get more pay, also, because I think we also heard they don't want just applause.

My testimony today will address the structural policies that have led to these disparate impacts on the COVID virus we've seen on communities of color.

I think everyone here probably knows that, outside of New York City, in the rest of the state, people of color suffer from COVID, and died of COVID, at a rate of four times that of White people.

In New York City those rates are twice that of White people.

This is unacceptable.

There is no biologic or genetic reasons for these disparities. It is socially constructed.

And I want to talk about, now, two reasons, besides, you know, all the social determinant health and essential workers.

I think there are real health-policy issues that this body, the New York State Legislature, can address, that have led to these disparities and helped reinforce these disparities.

First of all, medical care is unaffordable and there are disparities in health-insurance coverage.

Obviously, enacting the New York Health Act would resolve that.

But, I think it's really important to really think about what medical debt looks like in New York.

We helped a woman, Janet Mendez, who was profiled in "The New York Times," with a $400,000 bill for her COVID treatment.

These kinds of bills, and what is happening out there, are traumatizing patients. They are

fearful for seeking care.

In "The Albany Times Union," you know, we are seeing the testing sites, even though there are federal funds for them, are billing extraordinary prices to uninsured New Yorkers. And that can't happen.

Of course, hospitals, we did a study that was released in March. It showed New York State's so-called "non-profit" hospitals have sued 40,000 patients, residents of New York, in the last five years.

These lawsuits disparately impact people of color.

For example, in Syracuse, 41 percent of the community of color have medical debt.

On the other hand, White, that number is just 14 percent.

So that's over three times the rate.

And those kinds of disparities are seen around medical debt throughout the state.

In addition, I want to briefly mention that the hospital capacity is unfairly allocated and unfairly resourced in New York State.

We're missing 24,000 beds over the last 20 years; they've been closed. And those closures

have happened in rural areas and communities of color and urban areas.

So, for example, Queens has 1.5 beds per 1,000 people, while Manhattan has 6.4.

In other words, Manhattan has almost six times, five times, the number of beds that Queens does.

And similar experiences are happening all over this state.

Our pool that is designed to support safety-net institutions, called the "indigent-care pool," is woefully misallocated. We spread it around like peanut butter.

No other state provides indigent-care funding, disproportionate-share hospital funding, to every single hospital in the state.

We do.

It's not fair.

That means the safety-net hospitals have, basically, been shorted $13 billion over the last 20 years.

That's not okay.

And, that, there's no -- that's why we're seeing closures of hospitals. We're missing four hospitals, for example, in Queens, near

Elmhurst Hospital. They could not survive without this safety-net support.

It was brought through rate regulation, hospital rate review -- we all remember [indiscernible] -- and with this indigent-care pool being properly allocated.

Now, let's talk about the federal CARES Act money.

I think Assemblymember Kim was asking about this, and so was Councilwoman Rivera.

The CSS has just finished a new analysis of the CARES Act money.

All in all, Health and Hospitals, for example, received $68 million per hospital.

New York Presbyterian alone, just got $570 million over these past six months.

That's not fair.

We can't -- so it's -- it's -- it's -- it's just not a correct allocation.

It's also misallocated around the state.

Franklin County received 297,000 per COVID case, while Putnam received $2,000 per COVID case.

SENATOR RIVERA: If you could finish [indiscernible cross-talking] --

ELISABETH BENJAMIN: And Manhattan

[indiscernible cross-talking] --

SENATOR RIVERA: -- finish your thought, Ms. Benjamin.

ELISABETH BENJAMIN: I know my time is up, and I look forward to your questions, because I have so much to say.

Thank you.

SENATOR RIVERA: Thank you, Ms. Benjamin.

Followed up by Anthony Feliciano, director of Commission of Public -- of the Public -- on the Public's Health System.

ANTHONY FELICIANO: Thank you.

Again, my name is Anthony Feliciano. I'm the director of the Commission on the Public's Health System.

[Indiscernible] a Latino, and not only just as the director of our organization that cares about access to health care.

It pains me that we have to even talk about how many Black and Brown people died more than Whites, and also older adults.

It could have been prevented.

And all I can come up with is that, we have an indiscriminate virus that was unleashed in racially unjust systems, and our health-care system

is included in that.

And -- and all I can -- but I can be angry -- I can't be angry at the virus.

I have to be angry at the state department of health, and federal, city, and state executive branches, because they're accessories to this issue.

This is -- they compounded this tragedy because of years of decisions around state budgets, allocation to the safety-net hospitals, and, also, being influenced by political associations in terms of what's going on.

And so if we really want to honor, or think about how we prevent this and take care that we don't go back to this, we need to have a better and more fairly funded health-care safety net. But, also, we have to have a more prepared -- overall prepared health-care system.

And one of the ways that we need to think about it is, we can't go back to cutting more Medicaid.

It is -- we compounded the tragedy again by having custom Medicaid.

You know, we should be revisiting that.

And if we can't, and we need to find aid, and we can't get it from the federal government, then we

need to look at alternate revenue sources.

Judy Gonzalez talked about, we have to tax the ultra-rich.

We need to find other sources to help.

The other thing is that, all of us, even the hospitals agree, that we have to increase Medicaid reimbursement, but it really should be targeted to support the safety-net hospitals.

There shouldn't be, again, a play of where it gets distributed and where it goes.

It is -- I feel that we spend a lot of time, knowing that our health-care system, [indiscernible] Health and Hospitals, essentially, were there.

And if they weren't around, I can imagine how many more deaths, in particularly, Black and Brown communities, would have occurred.

And the other thing is the indigent-care pool. It's been mentioned before.

The ICP funds need to be better targeted to the essential safety net.

Many of us fought for changes there. And while we got some incremental, we're at the time where we can't wait for the epidemic to end.

We need to have our safety net strengthened and supported, financially, through the ICP.

Then there's this issue about some shared sacrifice.

We need our wasteful executive pay and non-patient care spending addressed.

These exorbitant salaries from CEOs, they need to be addressed.

We can spend our money better, in better ways.

And then I want to go into, really, what -- while this is focused on hospitals, hospitals are made up of a community of workers, and they're anchored in communities.

And so we need to address this not just as a focus on hospitals, but a focus on where they're serving, and who -- and what they're doing. And then front-line communities and workers need their support.

So we have to address rachial disparities.

We have to expand more funding for systemic responses to the [indiscernible] of health.

We keep failing in that in every so-called "health-care reform," or body that's being created, and disguised as a way to cut more Medicaid, or to make reforms that benefit the hospital, but not benefit the communities.

And we need an accord decision-making of workforce and communities, particularly organizations that are run by people of color, in terms of what we're addressing around racial disparities, and what are we doing around the funding streams, and the inequities that are there, just along with the funding streams.

I also want to just urge, you know, while we have to increase surge capacity, we've got to think about a moratorium on hospital closures. We have to revisit how decisions are being made on the long run.

We need to have more community involvement, and the community is, it is not decisive in terms of what's convenient in terms of what community.

I'm talking about really diverse set of folks, real stakeholder, who are not just brung at the table when it's convenient, but are part of the entire planning, part of the actual designing.

And many of us will mention it many times over. Many of us have been at the table, and it hasn't been real engagement.

And so I have to fault all those things of why we have so many Black and Brown people that died, because we have years and decades of

decisions.

It's not alone this governor. There's been plenty of governors that have done this.

But this governor is now in power, and he has the regulatory, with the state department, to make change; and, instead, they're not doing what they need to do.

And we're going to continue, when a spike comes, to have the same problems all over again, and the same traumas, and the same pain, going forward.

So we have to also -- part of my -- also my demands is also around data disaggregation and health-care readiness.

Like, let's go back and think about:

What it means to do community health planning.

What it means to really disaggregate data so it really shows a real picture, so we can target the funds to the real needs and community health needs.

And then, let me just say, that we need to pass --

SENATOR RIVERA: Can you wrap up?

ANTHONY FELICIANO: -- the New York Health Care Act.

But we need to understand that insurance is

not just access -- it's not about all access.

We need to address these inequities, and as part of this funding, and part of the decision-making.

Thank you.

SENATOR RIVERA: Thank you, Mr. Feliciano.

Next we will hear from Judy Wessler.

JUDY WESSLER: Thank you.

I submitted written testimony, so I'm going to read little parts of it.

But the major, first I want to say, thank you for allowing me to testify, and, also, just associate myself with remarks by both Chair Riveras, the council and Senate chairs, and Assemblyman Gottfried, about racial inequities and the safety net, and how that needs to be the focus.

And [indiscernible] what we have learned -- what have we learned from this pandemic?

I didn't learn, but, certainly, have had reinforced, the fact that not only do we live in a racist society, city and state, we are also trying to survive in what amounts to an institutionally-racist health system.

And it's systemic, and institutional, and that's part of the problem, and then we have to work

on that.

Not the folks that we had representing workers earlier or their workers, but the institutions and their policies.

And, certainly, the State plays a very, very important role in that.

I've said that the legislature was wonderful in responding. And we actually have a definition of "safety net" in state legislation, only because you all did it for two or three years, until the governor decided not to -- not to veto it again.

But we don't use that, or it's used very indiscriminately.

And I have several examples of the things that I've been seeing over the years, which I will not trouble you with, but just go on to say, that, you know, there are things that I know some of you have asked, what the state legislature can do?

And a couple of things are:

You've got to open up the process.

Right now, there's at least one academic medical center leader who is being the, quote/unquote, voice for the system to the governor, and does not represent our interests, certainly, and I'm not sure whose he does.

And they've been asked to do a look at the racial inequities, and they're really using inappropriate people to do that.

So one thing you can do is, to ask for a broadening of that request, and what the outcome of that request will be.

And so my fourth question was: What did we learn from this?

And -- sorry.

Hopefully, we now recognize the depth of the impact of systemic racism.

And with this recognition, we now need to work together to change what we see.

One of the things, and Anthony started to address this, is we do need some community-based health planning that brings in people in those communities, so that there's an understanding of what the needs are and how they should be addressed.

But more than that, we need to look at how resources and dollars go out, and where they go, and how they're concentrated.

When, you know, the pandemic first broke out, what did the governor do?

He put resources into Midtown Manhattan, where people were getting sick in Queens and

Brooklyn and The Bronx. And, you know, after a time, he finally did something about that.

So we've got to have a different kind of thinking.

And in terms of funding and resources, if there's going to be Medicaid cuts, and we hope there won't, but, looks like there might be, that they'll be -- that there not be Medicaid cuts for the essential safety-net hospitals that have been already defined in legislation. That they be protected from those kinds of cuts.

And then, also, we need focus on resources going back into, or initially into, community-based health-care providers in communities that have been identified as needing those services, and making sure that we don't have to rely as heavily on our hospitals.

We should have had some intermediary so that the hospitals didn't get overwhelmed. And we need to start thinking in those terms.

And we would love to work with you on, you know, some of those solutions, and how to -- how to make it work.

Thank you.

SENATOR RIVERA: Thank you, Ms. Wessler.

Next we will hear from Luis Ut --
Lois Uttley, women's health program director for Community Catalyst, and coordinator for Community Voices for Health System Accountability.

That must be one heck of a card, ma'am.

LOIS UTTLEY: CVHSA, is what we shortened it to.

And HSA is referring, of course, to health systems agencies, which used to do health planning in this state, and we could use it again.

I'm very grateful for the opportunity to present some comments on behalf of CVHSA.

It's a growing statewide alliance of community and health advocacy organizations.

We're trying to give consumers a greater voice in determining the future of their local hospitals.

And I'm going to focus specifically on state health policies, such as certificate of need, in my recommendations.

You've heard much about the disparate impact of COVID on Black and Latinx communities.

And you've also heard that many of the neighborhoods where Black and Latinx workers live, New Yorkers live, and seek medical care, are the

very places where hospitals have been closed down or downsized in recent years, and where even more closures are proposed.

More than 40 hospitals have closed across the state over the last two decades, and other community hospitals have been taken over by some of the large health systems, which then proceed to downsize or merge them, and force local patients to travel outside their communities to system hub hospitals, often academic medical centers, for inpatient care.

Pending health-system proposals will only worsen these inequities.

And I have two examples for you, and it's a sharp contrast.

One is, the proposed closure of Mount Vernon Hospital that you have heard referred to here.

This is a city that is 64 percent Black, and has suffered one of the worst COVID-19 rates in Westchester County.

The residents will be left with only a freestanding ER and ambulatory care, and would have to be sent out of the city for COVID-19 treatment and other inpatient care.

And you heard about the dangers of transferring patients like that.

Meanwhile, the Northwell Health System wants to spend $2 billion on upgrading and doubling the size of Lenox Hill Hospital in the Upper East Side, a largely White, affluent community with low COVID-19 case rates.

The complex would boast a huge tower, single-occupancy patient rooms, and luxury amenities designed to make it a destination hospital.

This is not right. This is inequity [indiscernible].

So, we want to urge several things.

First, I want to echo the call for a moratorium on State consideration of more proposed hospital downsizings and closings, or, major construction projects that have no obvious health-equity benefit.

These transactions should be put on hold until the department of health has conducted a thorough evaluation of the true need for hospital inpatient capacity across the boroughs in New York, and in many of those rural areas we have heard and talked about in New York State.

Second, we urge the introduction of a health-equity impact assessment into the certificate-of-need process.

This would require health facilities to explain, specifically, in their CN applications how their proposed projects would improve health equity, such as by filling geographic gaps in access to care, and, make sure that they are going to actually improve outcomes for Black and Latinx New Yorkers, low-income communities, women, LGBTQ people, people with disabilities, and also rural residents.

Finally, we must have more consumers on the New York State Public Health and Health Planning Council.

Governor Cuomo ordered the commissioner of health to appoint two consumers to this council called the "PHHPC" last December.

To our knowledge, these appointments have not been made.

We urge speedy appointment of them, especially of representatives from groups that can really speak to the specific needs of low-income consumers and communities of color.

We know, and commend, both houses of the legislature have passed a bill to add two consumer states to the PHHPC.

We urge the governor to hurry up and sign this bill, and get those consumers appointed, so

that we can have real consumer voices on this important council, who can raise the kind of questions that need to be asked about these health-industry transactions.

Thank you so much for the opportunity to present testimony.

SENATOR RIVERA: Perfect timing, Ms. Uttley. You've practiced that.

I will recognize myself for 5 minutes.

I'm sure that most of you folks probably have tuned in for most of the day, so you probably have heard most of the testimony that we've heard so far.

I'm going to go back to a question that I asked of the commissioner in the morning, because I think that, probably, certainly everybody who is on this panel, and I'm sure that many of my colleagues --

By the way, my time is not moving, which I certainly don't mind, but it's not fair to my colleagues. So I will wait to make sure that my 5 minutes are up.

Thank you.

-- so, anyway, when we -- there's many of us, certainly on this panel, and many of my colleagues, and myself as well, were not surprised when it

became clear, the numbers started to come out as far as the deaths, as far as where the hospitalizations were, et cetera.

We were not surprised of where they were happening, who were the folks that were being struck the hardest, because we have been fighting for health equity, period, for a very long time, most -- all of us in different -- you know, different capacities.

So the question that I have for you is the one I posed to the commissioner this morning.

From your perspective, particularly on those first three weeks of April, when, again, this was not a surprise to many of us, but the data started making clear that the places where people were dying and where most resources were necessary were hospitals that are safety net, that are serving people of color and poor communities across the state.

So the question is: What is your perspective on whether there was a calibration from the State, in as far as the resources and the guidance, to make sure that the resources went to where the -- the places where it was actually necessary?

Anybody can take it.

JUDY WESSLER: I can't tell you definitively, but from what I saw, the answer is absolutely not.

You know, that tent that was set up in Central Park as part of Mount Sinai, again, in Manhattan, rather than in the boroughs where there were the most people sick, and not -- I hate when people use the word "cases" instead of "people" because it really dehumanizes it.

But, no, the resources didn't go, at least initially.

Finally, I think after some of the data really became public and the media paid some attention to it, that there was some reallocation.

But initially, no.

SENATOR RIVERA: Got you.

Anthony or Elisabeth?

ANTHONY FELICIANO: If I can add:

I agree with Judy, but, this goes back to what I think the thread of all of our testimonies have been.

Who you put into decision-making and into power to do that, there's a problem.

If you want [indiscernible] as if people of color were not going to get hurt, and then you want to pay an association to do a study on us, you know,

to figure out why, that's a problem.

It should be, what is happening, and what can we do? should be more of the research, than saying "why?" because we know the "why."

The other part is, when you keep hiding the data, and you don't disaggregate it in ways that can actually show you a proper picture, you can continue creating those delays in terms of where the resources should go and the funding.

SENATOR RIVERA: And you believe that the data has not been segregated in the way that it needs to be?

ANTHONY FELICIANO: Yeah.

We're still fighting right now, even at the city level, for data that could be better disaggregated, even by certain -- by race, ethnicity, and so on.

Yes, they done better, but it doesn't yet -- it's not yet there in terms of addressing -- giving a picture of the inequity.

SENATOR RIVERA: Got you.

Ms. Benjamin.

ELISABETH BENJAMIN: And then data that has been released, for example, the CARES funding data, the idea that, you know, I mean, Franklin County has

52 COVID-positive people, about $297,000 per COVID-positive person, whereas Putnam County got 2,000 for its 1400 COVID-positive people, and Queens, you know, got $7,000 for 68,000 COVID-positive people.

So there's a crisis in how the structure of how we allocate our resources amongst hospitals.

And I think that's what all of us are talking about: that we have to rethink -- we just have to start over on how we're reimbursing hospitals and getting so-called "non-profit" hospitals to behave like the charitable entities that they're supposed to be, and really serve all people --

SENATOR RIVERA: Got you.

ELISABETH BENJAMIN: -- not just [indiscernible cross-talking].

SENATOR RIVERA: Got you.

Ms. Uttley, do you want to add anything?

LOIS UTTLEY: Well, I would just add that, as I understand it, Mount Vernon Hospital, which is threatened with closure, had two floors that were closed, mothballed, by Montefiore, but had capacity for 80 beds.

Did they reopen those to serve the people in Mount Vernon? No.

Instead, all the attention was on the Javits Center and a ship that would come to Manhattan.

And, meanwhile, the patients from Mount Vernon --

SENATOR RIVERA: Since I only have 25 seconds, I think I know the answer to this question, but, do you believe that having the New York Health Act, that would guarantee health care for every single New Yorker, regardless of who they are; regardless of their wealth, their status, their immigration status, et cetera, do you believe that that would be helpful in putting it into place?

ELISABETH BENJAMIN: Yes.

LOIS UTTLEY: Yes.

JUDY WESSLER: No, because it doesn't change the question of access.

SENATOR RIVERA: Ah.

JUDY WESSLER: It does reimburse, but it doesn't change, you know, what happens to Black and Brown people, what happens to people who don't speak English, what happens to people who live in communities where there aren't the resources that are needed.

Yes, it's a very important step, but it does

not change access.

SENATOR RIVERA: Thank you, Ms. Wessler.

My time is expired.

Assembly.

ASSEMBLYMEMBER MCDONALD: We will now go to Mr. Gottfried, for 5 minutes.

ASSEMBLYMEMBER GOTTFRIED: Thank you.

So this has been a terrific panel.

Almost every question I would ask, if I had a whole hour, has been talked about, and my question answered.

Bud I'd like to ask any of you who would like to comment on this a little more:

On the question of hospital capacity, and control of hospitals, have we -- a lot of people have said we overcut capacity.

Is it a question of overcutting capacity, or, is it a question of which hospitals got closed, and which communities were being served by the hospitals that got closed?

And, in terms of control of the remaining hospitals, what are the consequences of the consolidation of power in our hospital system in the hands of the big and predominantly rich academic medical centers, all of which, in any other part of

our economy, we would be chalking up to White power and corporate power?

How does that play out in the hospital world?

LOIS UTTLEY: The hospital beds, Chairman Gottfried, are mal-distributed.

There are too many in some places, like the Upper East Side, where, you know, Northwell now wants to put more beds up there, fancy beds; and not enough in other places.

So there has to be some system by which the department of health would do a good analysis of, what is the need for bed capacity in each of these places, and then evaluate these certificate-of-need proposals against that analysis.

So, such an analysis would say, no, we don't need any more beds on the Upper East Side.

We need them in Queens.

We need them in The Bronx.

We need them in Mount Vernon.

That's what we need.

ANTHONY FELICIANO: Don't trust the state department of health to do any proper assessment, unless it has community and health-care workers on the front line of -- actually, of how that's going to look like.

Why?

Because, when we have one of the first wave [indiscernible] we had -- there was the MRT, (the Medicaid redesign team), the first one.

It went through discussing, even Queens was [indiscernible] was considered underbedded, and they still allowed for a shutdown of hospitals there, even when the assessment showed that there was less beds.

The problem is, is the formula is so archaic, that it doesn't look in terms of also the staffing of those beds.

And so it needs to be a much broader criteria, how you're formulating what is considered "overbedding," or not.

And so that's an issue in itself.

JUDY WESSLER: Many years ago, we sued the state health department and the then-Health Systems Agency because they were basing decisions and approvals on just flaky -- what I call "flaky data."

And we negotiated a form that an institution had to fill out, that let you know who they served, where they came from, and, also, who the staff were, who the physicians and others were, that were providing this care.

Unfortunately -- and some people in the advocacy community don't support this, but, unfortunately, that form and that requirement disappeared.

Until we have the data that we need, we know what community needs are, but we don't know what the institutions are doing. And that's a missing piece.

ASSEMBLYMEMBER GOTTFRIED: Judy, can you send us some information about that litigation?

JUDY WESSLER: Oh, I'd be so happy to, Assemblyman.

Yes.

ASSEMBLYMEMBER GOTTFRIED: I thought so.

JUDY WESSLER: Yeah.

ASSEMBLYMEMBER GOTTFRIED: And we want to make you happy.

Thank you, I'd appreciate that.

JUDY WESSLER: I would be very -- I tried to get into some studies, but people were ignoring it.

So, again, until we recognize that there is racism, and, you know, resistance to changing the way that institutions and the State does business, and until we show what those issues are, it's just going to continue.

And it would be, pardon by language, a damn

shame if what we didn't learn coming out of this horror was to change the way we do business.

OFF-CAMERA SPEAKER: Judy, I gasped at that language.

JUDY WESSLER: I am so sorry.

I could have used another word, but I didn't.

ASSEMBLYMEMBER MCDONALD: We've heard worse, that's for sure.

SENATOR RIVERA: Thank you, Assemblymember. Your time has expired.

Currently, no members of the Senate.

Are there members of the Assembly?

ASSEMBLYMEMBER MCDONALD: The Assembly seems to be satisfied with the panel's comments.

Thank you.

SENATOR RIVERA: You people were amazing.

Thank you so much for being here with us today.

Enjoy the rest of your day.

JUDY WESSLER: Thank you for allowing us.

SENATOR RIVERA: Of course.

All right.

We now move on to the next panel, Panel Number 6.

Leading off there will be

Dr. David Pearlstein, president and CEO of St. Barnabas Hospital;

Dr. Bonnie Litvack, Medical Society of the State of New York;

Carole Ann Moleti, who has a lot of letters after her name, and is a certified nurse-midwife, along with MPH, DNP, CNM -- I don't know what any of -- many of those are -- New York Association of Licensed Midwives;

And, Patricia Burkhardt, also with a lot of letters after her name -- so a lot of very great folks here -- treasurer for the New York State Association of Licensed Midwives.

ASSEMBLYMEMBER GOTTFRIED: And do each and every one of you swear or affirm that the testimony you're about to give is true?

DR. BONNIE LITVACK: Yes.

ASSEMBLYMEMBER GOTTFRIED: A few more voices?

DR. DAVID PEARLSTEIN: Yes.

SENATOR RIVERA: Everybody's good?

ASSEMBLYMEMBER GOTTFRIED: Fire away.

SENATOR RIVERA: All right.

Dr. Pearlstein, lead us off, please.

DR. DAVID PEARLSTEIN: Thank you, Senator.

First of all, I want to thank everybody for

having me here.

And I need to state very clearly how proud I am, as the president and CEO at SBH, to have led, really, what was an incredible effort by my employees, by the health-care workers, and I couldn't be prouder.

I do have a submission that I will send to you.

I have pared it down quite a bit, but I hope you let me continue to actually talk for longer than 5 minutes here, but we'll see.

So COVID-19 has impacted all New Yorkers, but some are being impacted more than others.

Communities of color, the impact of these inequalities, is causing an already unlevel playing field to tip over.

Poverty rates and unemployment rates in communities of color, such as ours at SBH, were too high before COVID.

This is more worrisome now with the loss of jobs, school closings, and decreasing community support services which are impacting our community at a much higher rate than others.

The virus is also killing more people of color throughout the country.

Many say that COVID-19 doesn't discriminate and we're all equally vulnerable, but it doesn't mean that it isn't biased.

If you're a person of means with resources, income, and savings, you can still get infected by COVID-19, however, you can also weather it for a long period of quarantine, protecting your family and friends.

In much of New York City, and especially in poor neighborhoods of color, such as in The Bronx, social distancing and quarantining is a luxury that many cannot afford.

More starkly, according to the CDC and the New York City Department of Health's COVID-19 database, almost 90 percent of Bronx residents who died from COVID-19 had underlying health conditions, such as diabetes and hypertension. Compare that to an average rate for the other boroughs of 73 percent.

This is a direct -- directly a result of poverty. In a large part, this poverty is a direct result of decades of structural racism that has led to health-care disparities in our community.

In other words, the social determinants of health are real and the impact has been devastating.

The human, economic, and social cost of COVID are immense because, our service area, the pervasive poverty.

Most of our patients who are lucky to be insured are covered by government-sponsored health-insurance programs, mostly by the Medicaid program.

Even most of our elderly patients who may be covered by Medicare are also Medicaid-eligible due to that poverty.

And this doesn't even account for those undocumented members of our community who, despite working and paying taxes, receive few, if any, benefits.

An unfortunate truth is that, in the current health-care delivery system, St. Barnabas Hospital is not financially viable.

That fact's not new, and we've experienced growing negative margins over the past several years as our revenue has not kept up with expenses.

That is a direct result of rising labor and supply costs, and a period of flattened decreasing government-based revenue. But, just because we're not financially viable, it doesn't mean that we're not essential.

As an anchor institution, we employ over 3,000 people, half of whom currently living in The Bronx.

We serve as a trauma center, heart attack center, spokes center, behavioral-health hub. We have large women's and children's programs, as well as very busy substance-abuse programs.

Before COVID, our intensive-care units were full. It was hard to find an available bed on the inpatient units.

Our emergency department cares for 90,000 people per year, and our total ambulatory business number, over 650,000.

We train hundreds of residents and students per year.

And we delivered high-quality care. We have eliminated most hospital-acquired conditions right the top -- amongst the top hospitals for health first in quality.

We became a fiduciary for Bronx Partners for Health and Communities, which is part of the DSRIP program.

We're efficient, effective, we're outcomes-driven, and patient-centered.

After COVID, we're going to face an even

worse financial situation.

During the height of the pandemic, we expanded our inpatient capacity, including quadrupling the number of ICU beds.

We delivered the majority of our primary and specialty care via telephonic visits.

We closed our inpatient, pediatric, and detox floors to accommodate acute medical capacity.

We eliminated all elective cases.

We stopped receiving interventional cardiac patients.

We paid for all of our heroic staffs' -- members' meals. We covered the cost of their parking and their transportation.

We spent millions of dollars on supplies and capital and overtime. These were millions that were not budgeted.

Though our COVID volume has fortunately dropped, we have not completely recovered our budgeted pre-COVID volumes, and our outpatient services remain committed to delivering telemedicine in our community despite the technological and financial challenges and disparities.

The outlook is not rosy.

We're facing another $9 million in cuts from

the MRT II cut.

And although, thankfully, New York State has reassured us that they will continue to support us, we have no guarantee.

In addition, CMS, as you know, has continued to cut funding to hospitals that care for Medicaid patients.

At present, unless there is a change in this system, we are facing probably an over 10 percent operating loss which is not survivable.

We may not be alone, but as you heard today, that will not reassure our staff or our patients or our community if we have to close.

I'm going to state that very clearly:

A hospital and community that's been in the middle of one of the worst pandemics on record will not have a health provider in their community anymore.

I do not believe the current health-care system can survive the pandemic without changes.

Poor community hospitals and public hospitals which depend primarily on government payers, especially Medicaid, will not be able to make up the losses.

SENATOR RIVERA: If you could finish your

thought, Doctor?

DR. DAVID PEARLSTEIN: Yep.

Without a change we won't survive.

I just have two more comments, if you don't mind.

SENATOR RIVERA: At this time [indiscernible cross-talking] --

DR. DAVID PEARLSTEIN: The first comment is: We need to make investments in -- we need to make significant investments in technology because our patients don't have access to high -- to Wi-Fi.

And we need to --

SENATOR RIVERA: Second?

DR. DAVID PEARLSTEIN: Yes, sir.

SENATOR RIVERA: And second?

DR. DAVID PEARLSTEIN: I'm just telling you, the changes that need to be made are not pipe dreams.

SENATOR RIVERA: Thank you.

DR. DAVID PEARLSTEIN: We are the wealthiest nation on earth, and you know that.

We need to do this or we will not be able to live with ourselves.

SENATOR RIVERA: Thank you, Dr. Pearlstein.

Followed up by Dr. Bonnie Litvack from the

Medical Society of the State of New York.

DR. BONNIE LITVACK: Hi. I'm Bonnie Litvack, president of the Medical Society of the State of New York.

And I'd like to thank you on behalf of our more than 20,000 physician, resident, and medical student members for allowing me to testify today.

The COVID crisis has impacted the medical profession, and been like nothing that we've ever seen before.

The images of mass death and suffering are going to stay with our physicians forever.

We -- through the efforts of all New Yorkers, we were able to go from being a -- the center of the pandemic to being a national model for containing the virus.

And we would like to thank the governor and the department of health for their strong leadership.

I'd like to highlight a couple of things from my written testimony.

One has to do with physician burnout, which was a problem before the pandemic, but it's been exacerbated with the pandemic.

We're seeing more stress, and we are

concerned about more depression, suicides, and posttraumatic stress disorder.

The physician community, Medical Society of the State of New York is working with the hospitals on physician wellness programs. And we've invited them to join us and the AMA.

The Medical Society of the State of New York has also started a peer-to-peer program, which is a confidential program.

It allows physicians to speak to a peer and have a non-judgmental discussion, and gain some perspective. And, if needed, they can be directed to treatment. And that program is up and running. It's outside of the employer environment, and so it's a safe space for physicians.

Next, I'd like to highlight the PPE issues, which have already been talked about.

PPE was an issue early on in the pandemic, but it is still an issue currently for physicians.

Our physicians, we did a survey recently that showed that 72 percent of physicians said that they were still having difficulty with PPE, and that they had seen significant jumps, with nearly 40 percent saying that the cost had to go up more than 50 percent to pre-pandemic levels.

The ask here, is that you look at what other states are doing, like California, which has worked with their physician community to make sure that their physicians have PPE and it's not impacting patient care.

It is impacting patient care in New York.

Our survey showed that our physicians needed to cut down on their patient-treatment capacity by 25 percent.

Next, I'd like to talk about restrictions on delivering patient care, which has also been talked about before here and mentioned.

The bans on elective surgery meant that cancer patients often couldn't get surgery, and that people couldn't get cancer screening. And some portions of the state really had surges and were not able to take care of them, while others didn't.

The ask here, is that if there is a second surge, that the bans on elective surgery and procedures, if needed, be region by region, and that they not be just across the board.

The other issue with this, is that some of our physicians wanted to volunteer, but because of contract provisions, they were not able to volunteer at other institutions when they were furloughed.

And, again, it would be in the best interests of the public if those can be waived if there is another surge.

The last issue I really want to talk about is a scope of practice.

Many of our physicians and other health-care providers during the surge were working outside of their area of expertise and training. And this was necessary because it was an all-hands-on-deck approach.

That is why the liability protections were initially put in place, and why, if we have another surge, that these need to continue.

But we are not currently in a surge environment right now, and we're concerned about Executive Order 20255, which continues the waiver for the statutory requirements for physician supervision.

We are concerned about this because it's a de facto scope of practice change that sort of bypasses our state legislature.

And so, since we're not in a surge capacity right now, we feel that that should be overturned at the moment, and that the statutory requirements should be restored as soon as possible.

Just a couple of other little things that were mentioned earlier were:

That we do feel that the -- we do need to see increased federal funding.

And we also need to make sure that the health-care provider pool is increased, and telehealth is made permanent.

And, I thank you for your attention, and I'm happy to answer any questions.

SENATOR RIVERA: Perfect timing, Doctor. Thank you so much.

Next we will hear from Carole Ann Moleti.

And, Ms. Moleti, you have so many letters after your name, so I salute you.

CAROLE ANN MOLETI: Thank you for the invitation to provide testimony today.

I'm a certified nurse-midwife in New York City, and I specialize in the care of women at high psychosocial risk, who are at high risk of pregnancy complications and poor outcomes.

They include a disproportionate number of women of color and recent immigrants, and are residents of all five boroughs, over 35 years of practice.

The COVID-19 pandemic shredded the safety net

we have cobbled together over all that time.

On or about March 13th of 2020, most in-person visits were canceled and rescheduled as telephone visits, which eventually became video visits, with the exception of patients who had abnormal results.

Pregnant women were seen for initial visits, then again at 28 weeks, and then again between 36 and 40 weeks.

But in between that, many could not be reached by telephone. And those without Internet access could not avail themselves of video visits which allowed the provider to do visual assessment of general appearance, mood, and affect.

Patients were prescribed blood pressure monitors and scales so they could provide reading on subsequent telehealth visits. But with the shortages, few were able to obtain them.

Many pregnant women went three or months -- three or more months without a visit, or registered late in the second or third trimester of pregnancy.

This delay (video freezes) --

SENATOR RIVERA: Ms. Moleti --

CAROLE ANN MOLETI: -- the first time (video freezes) --

SENATOR RIVERA: -- you froze for about five seconds there, and you are still -- you're now refrozen.

CAROLE ANN MOLETI: -- patient --

Okay, I'm moving a little bit.

Is that better?

SENATOR RIVERA: Okay, now you're back on.

You were frozen for about 10 seconds.

CAROLE ANN MOLETI: Okay. Yeah, we have a thunderstorm here, so I may have to move around the room.

So testing was delayed, early recognition of problems as well.

And for the first time in as long as I can remember, patients were declined outpatient services until they applied for Medicaid, but the offices had been closed.

When patients did get into clinic, they waited for hours.

We found many with undiagnosed or untreated infections, fetal growth concerns, untreated anemia, uncontrolled gestational diabetes.

Many were anxious or depressed, facing social, financial, housing, or food insecurity.

Some were at risk of domestic violence and

becoming homeless.

And some needed direct admission to the hospital for moderate to severe preeclampsia.

We did perform some testing, and even minor surgical procedures, in clinic, so as not to send patients to the overburdened inpatient services or emergency room.

On the labor-and-delivery unit, patients were isolated from their support person until they were in a private room, which sometimes took hours.

All of them labored wearing masks (video freezes) --

SENATOR RIVERA: And we might have some more --

CAROLE ANN MOLETI: -- and results were often delayed.

Mothers who had any sign or symptom -- mothers who had any signs or symptoms or developed fevers from obstetrical complications were separated from their babies until COVID results, which returned many hours later, disrupting initiation of bonding and breastfeeding, and causing much emotional distress.

Most patients were discharged early. And though they were anxious to go home, often did not

keep follow-up appointments for incision care or monitoring of blood pressure, bleeding, or infection, which are the three main causes of maternal morbidity and mortality, which is very much in the news right now.

Many women were discharged on heparin to prevent blood clots, which must be injected twice daily.

Home-care visits for supervision of the injections and evaluation of maternal and newborn [indiscernible] or suspended due to the pandemic.

Social services were remote and not readily available.

Few women wanted to return for postpartum exams and family planning, and many were lost to follow-up.

I did have some remarks prepared about the lack of PPE, but I think that's been well covered, so I think I'll stop there and let Dr. Pat Burkhardt take over.

SENATOR RIVERA: Thank you, Ms. Moleti.

And, yes, next we will hear from Dr. Pat Burkhardt, treasurer of the New York State Association of Licensed Midwives.

DR. PATRICIA BURKHARDT: Good afternoon, all.

Glad to be here.

Somebody made a statement earlier on in these testimonies that talked about a different kind of thinking.

So I think I'm going to present to you all a different kind of thinking, because, right now, it has become very clear through this whole pandemic operation that we have inherent contradictions in our health-care system and structure, and we need to rethink and reformulate, so that should we have a future epidemic of some sort.

And we will. It's the one piece that everybody seems to agree on when it comes to the current pandemic.

So, basically, in a time of infectious-disease epidemics, hospital resources need to be used for those who are sick.

Now, despite what Carole said about some of her clients and patients that she was seeing, pregnancy and birthing are not sickness for the vast majority of women.

That is a healthy process, normal physiologic process, certainly that can go wrong at some point for some women; thus, the need for the clinicians to follow those women and be able to spot those

deviations from the norm.

But in the main, women, 85 percent, go through pregnancy and childbirth as healthy, well women.

In order to do that, we need to have a change in the structure of health-care delivery.

And I know this is about hospitals, so let's start with them, and this has already been said:

Hospitals are businesses, and I understand that.

At the same time, patients are -- through the hospital criteria, if you will, or model, patients are a means to generate revenues.

And so we have to somehow get some balance within the health-care structure and system, that, in fact, there is some equity, not just on a racial situation, but in a resource and a value-structure system for health-care delivery to pregnant and birthing women and families.

One of the ways to consider this is through community-based -- or, community-based care resources as part of an integrated health-care system that need to be envisioned and created.

So I'm talking about the future.

I'm not talking about this current pandemic,

except for the lessons we have learned and the realities we have encountered.

But the bottom line is, we need to have a solidly constructed and process-based, community-based, health-care system.

This critically includes midwives who lead birth centers, a concept that passed into law three years ago, but floundered in the DOH regulation writing and implementation process, as both Assemblyman Gottfried and Senator Rivera know.

Regulations were done, and finally, in December 2019, but continued to be a barrier rather than a pathway to opening birth centers.

And so, again, my ask, if that's the proper phraseology, is that hospitals within this system help foster.

And there were some efforts early on in the pandemic because of the terrible burdens that were put on families who couldn't have their support person, who couldn't have anybody with them, during their laboring process in the early days.

And so that, you know, Northwell was talking about trying to set up, you know, an out-of-hospital.

The bottom line is, if you're healthy and

only having a baby, and that's a big "only," but it's still just having a baby, you don't want to go into a den of germ-ridden reality that is a hospital filled with COVID virus.

Just don't want to do that.

And as Carole mentioned, a lot of their patients did not come follow-up -- back for follow-up. They just didn't want to stay involved at all.

Bottom line is, available clinicians at any time in our health-care system have to work to their strengths and the well-being of people seeking care, be they sick or well.

So physicians do real well with sick because their education, their skill set, is diagnosis and treatment of disease. That's what they do, they do it well.

Midwives, their knowledge and skill set is the support, the encouragement, the education, the counseling, of well women going through life's processes that women go through, be it pregnancy, be it delivery, having a baby; all of that.

One of the things that stymied me as I was trying to -- wanted to talk more about this, is the lack of data, that I could not access, could not

find, relevant to maternity-care services.

And I know many hospital services in Upstate New York have closed; they have closed their maternity units because of whatever reason.

And yet you can't find that data anywhere.

And when I was -- we were talking to DOH a while ago, trying to get these regs written for the birth centers, people at DOH were surprised that there were hospitals that had closed their maternity centers -- I mean, maternity units. Sorry.

And I have to stop because my time's up.

SENATOR RIVERA: Thank you very much, Dr. Burkhardt.

And now for questions, leading off, the Assembly.

ASSEMBLYMEMBER MCDONALD: I do not see any questions as of yet, although the testimony was very good.

SENATOR RIVERA: I will lead off, then, if there are no assemblymembers.

So I wanted to, first of all, just for the record, Dr. David Pearlstein, I appreciate you being here, sir.

You lead an institution that's in the middle of my district. We talked plenty in the height of

the crisis.

And as a representative of all the health-care warriors that you lead in that amazing institution, thank you for all that you did during that time.

But to -- but -- but I -- but I definitely want to linger on your testimony because, connected with the prior panel, we're talking about the thing that I just keep insisting, and that I wanted to make sure that Dr. Zucker acknowledged this morning, there are institutions that were in crisis before there was a crisis.

And so you have institutions, like St. Barnabas, which is a safety-net institution.

What is the percentage of people that you serve who are Medicaid patients on a regular year?

DR. DAVID PEARLSTEIN: It's approximately 88 percent right now.

SENATOR RIVERA: 88 percent of your patient base is Medicaid.

And so that -- and this is some of the neediest ZIP Codes in The Bronx, some of the most -- so you have people who have all of the, you know, high dia -- you know, high rates of diabetes, heart disease, et cetera, et cetera, et cetera.

And so the question I'll ask you is like the question that I asked of the commissioner as well, as well as the last panel: Did you feel that, at the height of the crisis, at the late March, early April, the first three weeks of April, when things were really, really, really, really bad, do you feel that there was a calibration from the health department and from the State to provide the resources, the type of that your institution needed and, hopefully, others like yours across the state?

DR. DAVID PEARLSTEIN: So, it's actually a challenging question because, I'll tell, we -- we all hands were on deck, and all of our staff and our management were involved in this.

But the fact is, is that there was a lot of communication. And we did get a lot of support from Greater New York and from HANYS and from the State, and from the City, for that matter.

And we did hit a critical moment, and I think you and I spoke at that time as well, where we were -- we were down to four ventilators, we were running out of gowns.

And through my conversations with you, with the City, and with the governor's office, we were able to get the supplies that we needed.

I think this hit us so hard and so fast that nobody really was prepared.

And I wish that weren't true.

And, hopefully, when this comes back one day, or another one comes, we will have learned from this.

But even my own organization, who had a CMO (a chief medical officer) who, back in January, was telling us to lock down all of our N95s, because he was watching the pandemic very carefully, he was prescient. We made changes pretty early to protect our inventory.

But I don't think any of us would have thought we would have quadrupled our ICU beds.

I mean, we had a hundred and, I think, nineteen intubated patients at some point. And, generally, we just have about, you know, 28 to 30.

So it was tough; it was very tough.

SENATOR RIVERA: So, again, thank you for you and everybody else that you lead in that amazing institution.

Kind of biased in that regard.

I want to make sure that the -- that both, Ms. Moleti and Dr. Burkhardt, I am glad that you're part of this conversation, particularly because

there have been -- we have -- and the reason we invited you, because we wanted to make sure that we -- the plight of women dying in childbirth is -- as you said, Dr. Burkhardt, childbirth is not a disease, so it should not lead, but, unfortunately, sometimes it does, and very much, unfortunately, the numbers talk about the maternal mortality amongst women of color, particularly Black women, is incredible concerning.

So your testimony today about the impact of COVID-19 on what was already a challenging situation is important.

If you had a couple of things, and I just have a minute --

I'm sure that maybe some of my colleagues, hopefully, will ask you as well so that you can expand.

-- but just for the last minute, what are some of the policies you think, top of the line, that we need to focus on as it relates to averting this type of situation amongst mothers in the years to come?

DR. PATRICIA BURKHARDT: Are you asking about how -- I mean, basically, decreasing the mortality, for sure.

The morbidity in the communities of color?

SENATOR RIVERA: Yes, ma'am.

DR. PATRICIA BURKHARDT: I think that -- you know, my experience, and I worked at Presbyterian for years, I taught at NYU for years, bottom line is, I think part of it is just inherent racism, as we all are becoming aware.

And a lot of people do not believe that exists. And those who don't believe it exists have not looked into their own souls well enough yet, in my view.

But the bottom line is, women of color, in my experience, are not treated well in institutions. And they're cared for not necessarily by the best providers.

Any woman who goes to Lenox Hill or Mount Sinai gets an attending physician. Any Medicaid patient gets a resident. Residents are first-year, second-year, third.

There's a whole inherent, in my view, mismatch of what the client's/the woman's needs are and what the institution provides her in terms of care that she gets.

Midwives do a better job because they are licensed providers. They're not learning to be

midwives.

SENATOR RIVERA: Thank you, ma'am.

Thank you for your testimony today. And, hopefully, some of my colleagues follow up. But I'm glad that we have your written testimony to include into the record.

That is my time.

Assembly?

ASSEMBLYMEMBER MCDONALD: We'd like to recognize Chairman Gottfried for 5 minutes.

ASSEMBLYMEMBER GOTTFRIED: Yeah, I have one, maybe two, questions for Dr. Litvack.

You talked about making, quote/unquote, telehealth permanent.

I mean, we enacted an extraordinarily broad telehealth statute quite a number of years ago.

We passed something a couple of months ago that seemed aimed at making -- making it more eligible for Medicaid coverage.

And I never had it quite clear, but there was, apparently, a question of whether federal Medicaid covers all telehealth services or not.

Can you maybe explain what it is that you think we need to make permanent that isn't already permanent?

DR. BONNIE LITVACK: So I think that the State has done a fairly good job on that. And we appreciate the legislation that was just passed in the month of May or June on the State side.

But there's still more work to be done because a lot of our patients in New York are covered by ERISA plans, and so those are under federal. And many of those larger companies are ending their telehealth coverage as of the -- September, October.

And also, on a national level, it's not clear that those are going to be made by the federal government permanent.

The other thing that's, you know, very important here is that we need to make sure that, when we have this within the state and outside of the state, that there's payment parity.

And so by that I mean that, you know, the physicians and other providers are paid the same whether a patient is in the office or whether they're on telehealth.

ASSEMBLYMEMBER GOTTFRIED: Okay. If you --

DR. BONNIE LITVACK: And the last thing was, what we enacted in New York I believe was for Medicaid patients only.

ASSEMBLYMEMBER GOTTFRIED: Yeah.

If MSSNY has or could put together a memo on that whole topic of what it is you think New York needs to do differently to give better coverage for telehealth, that would be very helpful.

And if you can just email that to me.

And just, can't resist, on the question of the restrictiveness of ERISA plans, when the New York Health Act becomes law, we won't have to worry about ERISA plans.

So you can just make that as a note to self.

DR. BONNIE LITVACK: Right.

Yes, we're happy to send along a memo to you on all the information on telehealth.

Thank you.

ASSEMBLYMEMBER GOTTFRIED: And if I've got maybe a minute more, you talked about scope-of-practice issues in -- I guess, in some of governor's executive orders.

DR. BONNIE LITVACK: Uh-huh.

ASSEMBLYMEMBER GOTTFRIED: Can you just say a little more about what those were?

DR. BONNIE LITVACK: So in the governor's executive order, he had suspended the statutory requirements for physician supervision for nurse

practitioners, nurse anesthetists, and physician assistants.

And those -- he just recently re-upped on those, and so that is continuing.

And so we're concerned about that, as I said, because it's becoming that it is a de facto scope-of-practice change on a broad level, and we're seeing things that are not related to COVID.

We've had a -- some of our physicians have reported that surgical centers and some dental sites have seen some nurse anesthetists that are applying to be the sole anesthesia provider at these outpatient offices.

And that's not clearly what this was intended to do. This was intended to be for COVID.

ASSEMBLYMEMBER GOTTFRIED: Okay. Thank you.

That's it for me.

SENATOR RIVERA: All right.

We're good in the Assembly?

ASSEMBLYMEMBER MCDONALD: We're good in the Assembly.

SENATOR RIVERA: We're good in the Senate.

Thank you all for your patience, and for being here today, and thank you for the work that you do every day to keep New Yorkers healthy and

safe.

DR. DAVID PEARLSTEIN: Thank you.

SENATOR RIVERA: Thank you, folks.

Next panel, we'll be joined by Ralph Palladino, second vice president of DC37;

Debora Hayes, upstate area director of CWA District 1;

And, Fred Kowal -- I hope I'm pronouncing that name correctly -- statewide president of United University Professions.

We'll wait for them to pop on here.

ASSEMBLYMEMBER GOTTFRIED: Uh, yes, am I --

SENATOR RIVERA: You are. We can hear you, sir.

ASSEMBLYMEMBER GOTTFRIED: Okay.

Do each of you swear or affirm that the testimony you're about to give is true?

FRED KOWAL: I do.

ASSEMBLYMEMBER GOTTFRIED: Everybody?

Okay. Fire away.

SENATOR RIVERA: All right.

So we have Ralph Palladino -- seems that we are missing Mr. Palladino for the moment.

Since we have Mr. Kowal --

Oh, we have Debbie Hayes.

Good.

So, Ms. Hayes, did you hear the Assemblymember's question?

DEBORA HAYES: I don't believe I did.

ASSEMBLYMEMBER GOTTFRIED: Oh.

Do you swear or affirm that the testimony you're about to give is true?

DEBORA HAYES: Yes.

ASSEMBLYMEMBER GOTTFRIED: Okay.

SENATOR RIVERA: All righty.

So until -- so, Ms. Hayes, why don't you lead us off.

DEBORA HAYES: Okay. I can do that.

Good afternoon.

I'm Debbie Hayes, the Upstate New York area director for the Communication Workers of America.

And I'd like to thank the Senate and Assembly committee members for allowing me the opportunity to testify on behalf of the 15,000 health-care workers that CWA has in New York State.

I want to start by acknowledging, and thanking, the tens of thousands of brave and dedicated health-care heros in New York who have been on the front lines of this devastating battle against COVID-19, a battle that many of them are

still fighting.

CWA has reached out to hundreds of our members as we debrief this crisis, and they've described to us the conditions that they worked under through the high inpatient days of the spring 2020.

Members told us of intense pressure for caring for patients with a disease they knew little about, hoping they were providing the right care and treatments.

Members were begging for the right personal protective equipment, and were just hoping to keep themselves and their families safe from disease.

Members needing, on a daily basis, more help than was available.

Members who wrote "goodbye" letters from the dying, FaceTime-worried family members for one last visit, and wrapped more bodies for the morgue than many saw in an entire career.

Members who were forced to work, once they were diagnosed with COVID-19, as long as they were not showing symptoms.

We have a workforce that is exhausted, traumatized, and suffering from posttraumatic stress syndrome.

Our takeaway, is that our issues must be dealt with before a second surge in the coronavirus is upon us.

Throughout the crisis we have been greatly concerned for the health and safety of our front-line workers.

While we are grateful for the administration's diligent efforts to increase the supply and distribution of necessary PPE at our health-care facilities, even in May, three months into the pandemic, many of our health-care workers caring for these patients were still facing shortages, and being forced to operate under the CCD's supply optimization guidelines.

As you can imagine, this put enormous stress and worry on members who, again, had that fear for themselves, their patients, and their families.

While the pandemic stretched our hospital system to a point we were not prepared for, many of the issues of COVID-19 exacerbated what have been longstanding issues in our hospitals.

In order to protect our health-care workers, our hospitals, and to ensure the best quality of care for all New Yorkers, we need a massive investment in our health-care system, in our

hospitals, and in our health-care workers; an investment in the state.

I'm running out of time, and I want to make sure that I get to a point that is of significance, and that is safe staffing.

So while there were steps taken that were necessary because of the financial toll on hospitals, in order to cut costs, we now have members that are being laid off and staffing levels have been cut.

And we need more staffing, not less.

For over a decade we've been fighting for mandated patient-to-health-care-worker ratios because understaffing in the hospitals was already an immediate patient crisis.

COVID-19 turned the crisis into a catastrophe.

We know that people have died because we didn't have enough staff to care for them.

The issue of understaffed and underresourced hospitals is not new.

As a union that has represented health-care workers in the state for over 50 years, we hear daily from our members about the impossible choices they have to make in terms of, how to do enough for

patients, how to get care delivered, without enough staff.

And (another audio/visual feed interruption) a year, documenting unsafe staffing levels in our hospitals.

I have a significantly longer written report that I've submitted, and I'll stop there because I'm out of time.

SENATOR RIVERA: Thank you, ma'am.

It will be in the record.

Now, Mr. Palladino, we did hear you there for one second, but we muted you because Ms. Hayes was not done.

So if you can figure out how to unmute yourself, there should be a window appearing in your screen.

Oh, well, Mr. Palladino went away.

I guess he pressed the wrong button.

Mr. Kowal, I'm not sure if I'm pronouncing your name correctly.

FRED KOWAL: Sure. I can go ahead.

Thank you, Senator.

And thank you to all the distinguished members of the New York State Legislature.

I'm Dr. Fred Kowal, president of

United University Professions.

And that's fine, Senator. Lots of different ways I've heard my name pronounced, and it's all good.

I want to thank you, first and foremost, for holding this hearing, but also for your long support for UUP, for our 37,000 members, and particularly the 13,000 who work at our academic medical centers at the University of Buffalo, at Upstate at Syracuse, at Stony Brook, and especially at Downstate in Brooklyn, which, as you know, was a COVID-only facility at the peak of the pandemic's first wave.

As a matter of course, actually, Stoney Brook turned into a COVID-only hospital as well, for all intent and purposes, because of the caseload that erupted in Suffolk County.

I would -- I'm submitting written testimony.

I really just want to emphasize a couple of key points to you today. You have heard a number of these themes.

I just want to bring them into focus in terms of our members and the issues that we are facing.

First, I think there's no question about it, we all know that there was a total lack of

preparedness for the COVID pandemic that struck the United States and New York.

In the case of the SUNY hospitals, the three SUNY hospitals at Upstate, Downstate, and Stony Brook, 10 years of underfunding, which, basically, has been kept in place by the legislature, but continuous efforts by the governor to eliminate the State subsidy for these hospitals, created conditions where our professionals could not do the necessary work. But they did keep 3,000 of COVID patients alive through the pandemic while also suffering losses among our own ranks.

The reality is, the lack of preparedness pointed out that there must be an investment in the SUNY hospitals in order for us to be prepared to treat patients, but then also to provide the medical education.

For years UUP has worked with the state legislature to ensure that SUNY hospitals get the subsidy that they must get.

After all, these hospitals bear the burden of fringe benefits costs and debt servicing unlike any other agency in New York State.

Those are huge costs, the subsidy is necessary.

But, also, the medical education that our future physicians and health-care providers are getting at these medical schools has never been more important.

What is clear we didn't have the personnel necessary to treat the patients, and, furthermore, the patients that we know are coming.

That's why, for the past two years, UUP has fought hard for the development of new programs, including the Medical Education Opportunity Program, a version of EOP, to bring in students from underrepresented communities of color into these medical schools, so that they can become the professionals of the future to treat patients across New York where they are desperately needed.

We also need resources, obviously, as you have heard, because of this severe lack of PPE.

Our union went so far as to purchase PPE for our physicians and our health-care providers because they were risking their lives.

And if it wasn't for the PPE provided by UUP, by the American Federation of Teachers, by NYSUT, for our front-line workers, there would have been more lives lost.

The final point that I want to make is also

on the issue of justice.

As much as our members put their lives on the line, it is horrible that, in fact, none of those workers have received any additional payment, whether you want to call it "hazardous-duty pay" or not, while they have seen every other hospital in New York City and across Long Island pay their people, and they should be paid.

What I am asking is whether or not we will tolerate a real two-class system, where some of the front-line employees get paid, but others do not.

We owe it to our colleagues, to our health-care providers, who are saving lives.

We know the second wave is coming.

I've heard previous witnesses talk about the psychological burdens.

We have seen it in our own members.

Without the compensation, without the financial support and the resources, there will be tragic burdens having to be borne by health-care providers across this state.

So I thank you once again for all your support over the years.

We need to do massive amount of work on health care in New York State, facing this pandemic,

and the future of health-care in New York State.

Thank you.

SENATOR RIVERA: Thank you, Mr. Kowal.

And last, but not least, so, Mr. Palladino, there you go, you are now on.

Nothing is wrong. We can hear you.

RALPH PALLADINO: Yes, thank you.

Sorry for the delay.

Ralph Palladino, Local 1549, District Council 37.

The Black Lives Matter protests and the COVID-19 pandemic has focused the light on the health-care disparities in New York City.

The New York City Health and Hospitals Corporation plays a central role in these communities, in saving lives and providing decent jobs.

This, in turn, helps keep the local economy alive.

The heroic work of our H&H front-line health-care workers includes 5,000 Local 1549 clerical members, also -- who also live in the communities they serve.

They are the first to greet the COVID-19 patients upon entry into the facilities.

They must be recognized and rewarded properly.

The duties and functions are key to generating income for H&H and the well-being of the patients.

[Inaudible.]

SENATOR RIVERA: Mr. Palladino, you have muted yourself.

RALPH PALLADINO: Over 8,000 COVID patients' lives were saved in H&H facilities after being admitted and successfully discharged.

Overcrowding did exist in most institutions, and 850 COVID patients had to be transferred because of this across the system. The system was able to absorb them.

Clericals performed registration duties, taking 15- to 20-minutes' face-to-face contact with patients entering the system.

Their work generates medical records and gathering insurance information.

Outpatient counselors assist patients in getting health insurance.

The current plans to open -- reopen are inclusive of the needs of clerical employees.

They have been provided proper PPE, masks,

and goggles, have been treated equally, Plexiglas, and other things, to help their safety and health in the crisis.

They also were provided child care during the crisis.

The administration of H&H and the union have been working together cooperatively, and when issues have come up, we have been able to deal with them internally.

Despite this, our members have experienced depression, felt stress, burnout, and experienced tears because patients were dying.

If not for the H&H's need for employees, the employee -- employee staff, because there are staff shortages, they had to take -- I'm sorry.

If not for -- Health and Hospitals had to hire private temps to take care of the areas that -- because of the short staffing of the clerical staff.

And them doing that kind of work, our kind of work, is problematic.

Now, H&H has experienced a $1.1 billion loss due to the crisis.

The system had to take into account staffing, supplies, and space utilization.

Traditional Medicaid rates were used to pay

the costs of care. And, of course, we know that they don't. They pay about $100 less than they should be.

More budget cuts will be deadly for the system.

Calls by some to reduce public services and furloughing laid-off workers, especially in public hospitals, is wrong.

The State needs to step up and help and assist our public hospitals.

The distribution of funding has always been unfair to public hospitals.

I've been at this for 25 years, and it's always been that way.

Underfunded hospitals had three times more COVID-19-related fatalities than others.

The state budget passed April 1st meant a $200 million cut to H&H's budget.

We can expect more of a cut in the State's "savings" allocation plan.

H&H has an administrative overhead of 1 to 3 percent.

1 to 3 percent only.

Over the years, the system has downsized severely, cut beds, and Local 1549 has cooperated

with them to streamline finances.

And so what the answer could be, is the fact that, looking at the state of the economy, is that the billionaires in New York State, since March, apparently, increased their wealth by $77 billion.

And you're telling us that they can't -- that they cannot afford to pay in taxes to help more for the state economy and for health care?

Business journals, politicians, and pundits say these rich people will leave the state if taxed more.

Studies, like the one in Stanford, show that's not true.

Another poll shows -- does not show that people leave because of taxes; it's because they seek other jobs.

So, in summary, H&H system holds the key to lessen health disparities in the city.

It's been, and will continue to be, the epicenter of the fight to protect the public health.

This is especially true, given the collapse of the employer-based health-care system.

H&H helps those who need the help regardless of their ability to pay, including immigrants.

SENATOR RIVERA: Mr. Palladino, if could you

wrap up, since your time has expired.

RALPH PALLADINO: Okay.

And so we cannot afford to lose funding with an overhead of just 1 percent.

We need the help.

Our members are asking:

Where is the shared sacrifice in this crisis?

We are not properly compensated, face layoffs and disease, while the rich and corporations don't even pay their fair share of taxes.

Thank you.

Sort for delay and mixups.

SENATOR RIVERA: You're quite welcome, sir.

We'll lead off in the Senate.

I'll recognize myself for 5 minutes.

Thank you all for being here.

We obviously had a panel earlier of workers as well.

And this is a panel that covers workers all across the state as well.

I wanted to give you a -- an opportunity to also answer the question, I've asked it a couple of times.

And I want you to give me a perspective from the workers as it relates to the changes,

particularly at the height of the crisis, so, late March, early April, so first three weeks of April, when there was such a need in safety-net hospitals and places that take care of people who are of poor working class and people of color, and these are the places that were most in need where most of the deaths were happening.

I'm just really trying to assess, since this -- these hearings, as I've said many times, are, both, about accountability, but forward-looking, what are the things that we need to do in policy-wise, the calibration that occurred from the State, as far as resources to institutions that required the help at the height of the crisis.

So from the workers' perspective, could you tell me a bit about how you felt the State managed that; whether they calibrated correctly during those times, to make sure that these institutions had the resources necessary to be able to serve the people who they serve?

RALPH PALLADINO: One thing I would say, if you don't mind, is that, if had the State had been fair in terms of the way they treat the New York City Health and Hospitals, and also the other smaller community hospitals, over the last

10, 15 years, maybe New York City Health and Hospitals and these community hospitals would have been able to take care of the situation much better than they did.

The crisis hit us slowly, but fast. Right?

So the thing is, had we been better prepared over the years, instead of cuts, cuts, cuts, cuts, and pressure, and, internal, having to reorganize and downsize, we would have been in a better position to deal with the situation.

That's the only thing I can say.

I can't speak to particulars between the State and the City and Health and Hospitals.

SENATOR RIVERA: Understood.

Any comment from either folks?

Go ahead, Ms. Hayes. We can't hear you. If you could unmute yourself, please.

DEBORA HAYES: Mute?

SENATOR RIVERA: There you go.

DEBORA HAYES: The majority of the members that CWA represents in health care are in the Upstate New York area.

And the procurement of PPE was an ongoing battle throughout the peak of the crisis.

So our facilities had people, full-time,

trying to get N95s, gowns, testing -- components of the testing that needed to be done.

And I don't think that that ever let up.

I know that they were required to report to the State what they had in terms of PPE, and how fast they were going through what they had.

But I don't know that the State was ever fully responsive to the needs, because we never felt the kind of relief that we were looking for.

SENATOR RIVERA: Mr. Kowal, do you want to chime in?

FRED KOWAL: Yes, Senator.

As I mentioned, the union, we had to dig into our own resources to buy PPE.

And -- but we do -- I do know that when we did reach out to the governor for assistance in the case of Downstate, first and foremost, they did all they could to get the PPE that was necessary. The same thing with the ventilators.

The difficulties that we encountered, and I could tell you horror stories, of trying to, literally, deal with middle-level businesses who were trying to find N95s anywhere in the country, and for that matter, anywhere in the world.

We spent weeks, literally, trying to track

down PPE. And we also know that the State had the same difficulties.

This was a national catastrophe, and I think what we tried to do was assist our members the best we could.

SENATOR RIVERA: But I just -- the last thing I want to do is just underline really quickly, I just want to make sure, because Mr. Palladino's point about the fact that there's -- this is a long-term thing, that there was a long -- long-existing -- you know, that this is not just something that happened now. There was something that [indiscernible] for a long time.

You are all in agreement with that, I figure?

FRED KOWAL: Absolutely.

DEBORA HAYES: Yes.

There's no question in our hospitals to deal with a surge and a pandemic to the extent that we had to deal with it.

We have been cut so during the years, our staff is so bare-boned, that a crisis like this, a pandemic like this, immediately pushes you into crisis.

And it's the workers -- the patients and the workers that always bear the brunt in this

circumstance.

SENATOR RIVERA: Thank you.

My time is expired.

Back to the Assembly.

Thank you all.

ASSEMBLYMEMBER MCDONALD: We will to go our chair, Mr. Richard Gottfried.

ASSEMBLYMEMBER GOTTFRIED: Thank you.

You know, it's striking how on so much of the really compelling testimony that all of you have given today, it is so strikingly tale-of-two-cities different from what so many other witnesses have testified.

One point of striking difference that I'd like to explore with you, as I have with some other panels:

All of the trade association people who testified at our hearings on long-term care, days ago, and today's hearing, the trade associations have all extolled the efforts of the Cuomo administration to reach out with them on a, practically, daily basis, to consult with them, to hear their input, to work things out, et cetera.

And it's been striking to me that none of the labor unions, none of the consumer advocacy groups,

have said anything like that.

And I assume -- correct me if I'm wrong -- that that's because you were not brought in for that kind of constant consultation and cooperation that management was offered.

Am I right on that?

RALPH PALLADINO: [Indiscernible], if you don't mind, New York City is a little bit different.

I mean, we worked very well with the people in the New York City Health and Hospitals.

The City administration and DC37, you know, always in touch.

So, you know, that's a little bit different.

We don't really hear from the governor directly in terms of that.

But I will say this:

Medicaid dollars need to follow the Medicaid patients.

Medicaid reimbursement rates need to meet the costs of care.

The well-off empires in New York City are getting the lion's share of the money, and they have for years.

This continues now.

We had no representation on the last MRT that

just took place. None at all.

So we had no stake in terms of the direction of the cuts that took place back in -- April 1st, except to protest against them and advocate.

So, that's all I can say.

I am very proud of the governor, the way he has acted and held things together for the state, and spoke up against the Trump administration and the things that they're trying to do to the state.

So I am not here being anti-governor.

My point is, that there's good and bad that we need to deal with, and I should say, disagreements and agreements.

But that's all I can say on the issue.

ASSEMBLYMEMBER GOTTFRIED: Thank you.

DEBORA HAYES: I would also say that, I have looked back on the work done in New York State, and am extremely proud to have been a part of the effort to bring us and our rates down to where they are today.

I speak because I feel that there will be a second surge, or another pandemic, that we will have to deal with, and we should be prepared.

I think that the workers or the unions representing the workers should have regular access

to the administration because, if there's any question as to what's going on on the ground, the people that are delivering the care every day are the ones that are going to be able to give you the best information.

FRED KOWAL: And, Mr. Chairman, I would say that, in the case of the SUNY hospitals, ultimately, you know, to put it bluntly, they are the governor's hospitals.

They are State hospitals, operated by SUNY.

And for the time that I have been UUP president, since 2013, I have always felt that we have been on our own, working with the legislature, to try to defend these institutions.

There's been a lack of advocacy on their behalf by SUNY.

And the governor has not been an ally and a supporter of the hospitals, and I've never understood why.

Their role is central during this pandemic, they have proven their worth.

We need to work together to make sure that these institutions continue to serve the public, and last.

For that, we need everybody at the table.

And we are eager to work with anyone to build a strong future for them.

ASSEMBLYMEMBER GOTTFRIED: Thank you.

SENATOR RIVERA: All righty.

We do not have members of the Senate to ask questions.

ASSEMBLYMEMBER MCDONALD: We have one member of the Assembly, and that would be I.

So I will just thank all of our panelists for their testimony. It's been instructive. It's always been collaborative and supportive.

It's not about bashing, but recognizing the issues and recognizing solutions.

Fred, a couple weeks ago, Fred, we were able to join a panel with the higher-ed panel. And, you know, there's some consistent threads here, which indicates to me that the problem is still there.

But the hazard pay, and you mentioned, rightfully so, that the privates and non-profit hospitals have paid it, although we heard on similar panels earlier, it took time and effort.

Obviously, because it's a State-run hospital, the State probably hasn't come up with that.

But can you give me a sense of comparability, what are we talking about in regards to dollars?

If you were to say, here's what they're getting at other hospitals, can you quantify that into what that would be?

FRED KOWAL: Yeah. What we can tell you, in part, because of the good work that all of the unions, specifically now, right now, we've had good activism at Sony Brook, where, SEIU, that represents the South Hampton unit at Stony Brook, and UUP, CSEA, PEF, have all joined together.

And then, also, of course, we have very strong advocates at Downstate.

The combined numbers look to be around 9,000 employees that were front line and, thus, deemed to be eligible.

And what we are asking for is what, you know, has been typical at the Northwell facilities, and that is, basically, around a 2500 bonus.

So if you do the math, you get an idea as to what we are talking about.

It is not an exorbitant amount of funds.

We are just asking for what others have received in a similar sort of work environment, to put it simply.

ASSEMBLYMEMBER MCDONALD: [Indiscernible], and I thank you.

And thanks to all of you.

And it goes without saying, and, tomorrow, if you guys are looking for something else to do, we will be having a labor hearing tomorrow, which our committee will be participating.

But, to me, you know, unions have been very strong representatives of our workforce.

But you being able to come to their time in need with PPE when it wasn't available, that's very meaningful, and you've done great work.

Thank you.

And with that, Mr. Chair, I think the Assembly is ready to rest.

SENATOR RIVERA: As is the Senate.

We still have two more panels, but we will have the last 10-minute break of the day before we power through to the end.

So --

RALPH PALLADINO: On behalf of our members, I want to thank you for inviting, by the way.

SENATOR RIVERA: Absolutely.

ASSEMBLYMEMBER GOTTFRIED: You're very welcome.

SENATOR RIVERA: Okay, folks, 10-minute break.

We will be back to get this thing done.

(A recess commences.)

(The hearing resumes.)

SENATOR RIVERA: Good afternoon, everyone.

There's an alarm going off behind me. I don't know if you can hear it, but, it's annoying me, so it might be annoying you.

There you go.

We're going to power through the last couple of panels.

The next panel will be:

Catherine Hanssens, Center for HIV Law and Policy;

Jessica Barlow, senior staff attorney, Disability Rights New York;

And, Marcus Harazin, coordinator, patient advocates program, for the New York Statewide Senior Action Council.

ASSEMBLYMEMBER GOTTFRIED: Okay. And do each and every one you swear or affirm that the testimony you're about to give is true?

MARCUS HARAZIN: Yes.

JESSICA BARLOW: I do.

CATHERINE HANSSENS: Yes.

ASSEMBLYMEMBER GOTTFRIED: Okay.

SENATOR RIVERA: All right.

Ms. Catherine Hanssens, please lead us off.

CATHERINE HANSSENS: On behalf of the Center for HIV Law and Policy, I thank you for powering through, as Senator Rivera mentioned, and for the opportunity [indiscernible] --

(Another audio feed interruption.)

CATHERINE HANSSENS: I'm hearing voices. Should I continue?

SENATOR RIVERA: You should absolutely continue.

CATHERINE HANSSENS: The COVID epidemic has laid bare what many New Yorkers living on the margins already knew: That in times of crisis, ad hoc decisions about who gets what care do not produce equitable access to life-saving services.

Assemblymember Kim's earlier questions about the many requests for guidance from the department of health I think are completely on point.

When the call was for guidance on ventilator access and emergency triage, Commissioner Zucker refused to respond.

New York's guidance on ventilator distribution during pandemics has serious gaps and is insufficient to protect the lives of people with

disabilities.

They address only the allocation of ventilators, which are not the only form of essential care.

COVID-19 patients living with disabilities need assurances of equal access to other respiratory therapies, medications, critical-care beds, and staff time, which current guidance fails to protect.

Professional hospital associations used the occasion of a major epidemic to pursue legislation, giving them near total exemption from any form of liability, which I think is an odd priority, in view of the massive medical mistrust common among many people of color who were disproportionately affected by this.

New Yorkers need assurances that, in times of scarcity, laws that prevent discrimination on the basis of age, disability, race, and gender will apply to the provision of critical health care.

The right time to fix protections for vulnerable New Yorkers during an emergency is before that emergency arises, and ensure that the resulting policy is comprehensive and includes input from all stakeholders.

The fact that New York avoided a

ventilator-rationing crisis during the first wave of COVID-19 is no reason to not act with urgency to fix this now.

Indeed, it is likely that we will again confront serious resource-allocation issues through either a COVID-19 resurgence or another lethal virus in the near future.

Seeing no buy-in or action from Commissioner Zucker, we propose that the legislature consider legislation, such as, codifying these rights, the rights to be free from discrimination, and the existing Hospital Patients' Bill of Rights.

Individuals must have confidence that, when they enter hospitals, they will not have personal ventilators taken away, or otherwise be discriminated against due to disability, age, or disfavored identities.

And, finally, the legislature should repeal Article 30-D of the Public Health Law, immunizing health-care facilities from liability.

This Emergency Disaster Treatment Protection Act drastically limits liability standards to the point that it is, essentially, insulating hospitals and their executive leadership from criminal or civil liability.

Stripping patients and family members of the ability to hold hospitals accountable for civil rights violations and other harm is just not appropriate.

Pandemics should not be used as a basis to encourage hospitals to put aside basic standards of care, which, when followed, actually insulate against liability.

Thank you.

SENATOR RIVERA: Thank you so much, Ms. Hanssens.

Followed up by Jessica Barlow from the -- senior staff attorney for Disability Rights New York.

JESSICA BARLOW: Hi. Thank you.

My name is Jessica Barlow. I am a senior staff attorney at Disability Rights New York.

DRNY is the designated protection and advocacy system for New York State.

The P&A system was created in the 1970s as a result of media coverage which showed the horrific abuse and neglect of children and adults with disabilities at the Willowbrook school on Staten Island.

DRNY provides free legal and advocacy

services to people with disabilities in New York State. And we also monitor congregate-care facilities to ensure that those living in those facilities are not abused or neglected.

I want to thank you for the opportunity to speak with you about how the COVID-19 pandemic has impacted the people that DRNY serves.

Today I will be focusing on medical rationing and its impact on the disability community, and, in particular, I'd like to discuss ventilator rationing at acute-care facilities.

In November of 2015, the New York State Task Force on Life and the Law and the New York State Department of Health published their ventilator-allocation guidelines in order to provide guidance on how to ethically allocate limited resources, ventilators, during a severe pandemic while saving the most lives.

As has been said, these guidelines contain serious gaps which discriminate against people with preexisting disabilities, and, in particular, individuals who are chronic ventilator users.

The guidelines explicitly state, that a chronic ventilator user who lives in the community and goes to an acute-care facility during a

pandemic, like the current one, can have their personal ventilator reallocated to another individual.

The guidelines acknowledge that this may place ventilator-dependent individuals in a difficult position of choosing between life-sustaining ventilation and urgent medical care.

And this is exactly the situation that DRNY's clients are in, and it's not a difficult position; it's an impossible and a terrifying one.

I recently spoke to a woman who is currently self-isolating on Staten Island. But when the pandemic began, she was in New York City, attending Columbia University, where she's currently pursuing her bachelor's degree in biology.

She lives with a neuromuscular disease which is not life-shortening, but does require chronic ventilator support.

She cannot breathe on her own at all, and uses a ventilator 24 hours a day.

In the spring, at the beginning of the pandemic, she began to hear rumblings from classmates and other ventilator users about New York State's existing ventilator guidelines, and so she sought them out.

She was horrified by what she read.

She knew instantly, if she was to contract COVID-19, she would not be able to seek care in an acute-medical facility without risking being forcibly extubated.

The guidelines specifically contemplated taking her personal ventilator away from her and giving it to someone else.

Since this woman became a chronic ventilator user more than 15 years ago, she never lets her ventilator out of her or her family's sight for this exact reason.

Even prior to the pandemic, and even prior to these guidelines, she and her family have experienced hospitals attempting to discharge her to skilled nursing facilities instead of back into the community with her personal ventilator.

She has always lived in fear of being institutionalized, but now she also lives in fear of needing medical care at all.

The guidelines tell her that, if she needs acute care during the COVID-19 pandemic, she cannot seek that care.

Should she go to a hospital, she will be forcibly extubated, and her ventilator will enter a

pool of ventilators, to be allocated according to triage procedures. Her personal ventilator will be given to someone else who is deemed more likely to survive with a higher quality of life.

These fears are shared by countless other individuals who are contacting our office every day, and who are chronic ventilator users.

This is part of a national debate, and in an effort to address these concerns, DRNY and other organizations, and even individuals, have filed complaints with OCR.

In many other states, these complaints have reached amicable resolutions that address the issues regarding rationing personal ventilators.

But, despite the pending claim, New York State's Department of Health is unwilling to contemplate a revision to its policy.

DOH states that's this is just guidance; that hospitals don't need to follow this, and it's not an official rule.

But the response from hospitals is, essentially, how do we not follow these guidelines when there's nothing else for us to follow and we're facing an unprecedented crisis of life and death?

Everyone seems to be pointing fingers at each

when there is a community of people that needs help and answers.

So it is DRNY's recommendation that the ventilator allocation guidelines be reviewed, and that these concerns be kept in mind.

The Task Force on Life and Law failed to even consider providing guidance that would not, under any circumstances, allow for a chronic ventilator user to be removed from their ventilator without another device being readily available for their use.

And that is the only acceptable approach.

Thank you.

SENATOR RIVERA: Thank you so much, Ms. Barlow.

Next we will hear from Marcus Harazin --

I hope that that's the corrected pronunciation of your name, sir.

-- coordinator, patient advocates program, for the New York Statewide Senior Action Council.

MARCUS HARAZIN: Good afternoon.

Thank you for inviting Statewide to speak today.

We run a state private patients' rights helpline, and a CMS-funded senior Medicare patrol

program to prevent fraud.

With the limited time that have I today, I want to talk about a couple of recommendations, specifically in the area of patients' rights.

Just as we learned during the recent hearings, that most citizens' knowledge about rights, like the access to the long-term-care ombudsman program, are very limited.

Most people don't know that there's a bill of rights.

So, when someone is waiting till someone is in the hospital to educate them about their rights is really too late.

So, really, really feel that now is an important time to kind of go back and look at the bill of rights, and look at how the State is educating communities about these rights, especially the vulnerable elderly population.

The pandemic playbook called for the suspension of many rights in order to sustain the health of the general public.

Some are really good, like dropping the three-day-stay requirement for post-acute rehab, but many were counterproductive. That's especially true for older adults who use five times as much acute

care as other adults.

Those rights include: Removing explaining why patients were being removed from a bed. Provision of a copy of the medical record. Patient visitation rights and seclusion.

We know that family visitation can be very helpful in the process of recovery, and we know that patients now know how to do this.

No one should be without someone to have social contact with.

New York should convene a group to develop pandemic visitation protocols and policies that could be built into pandemic plans.

The religious views of the patient must be honored, even during a pandemic.

For example, during last rights, the Jewish ritual of watching over a body of a deceased person, from the time of death until burial, should be honored.

Also, the State needs to revise the compassionate-care visitation rules for visitation at the end of life.

Communication with families is paramount, multicultural. And non-English speaking families really need to be provided with information they can

understand.

There are models out there on how do that better.

Too many patients were treated without the family knowing which hospital they were in or facility they were in, and patients died unidentified.

We need to keep families informed as to where the patient is, and the state needs a patient-tracker system.

Discharge-planning regulations were also waived, as the United Hospital Fund noted in their recent reports about post-acute care and COVID.

We need to reinstitute many of the discharge-planning requirements, including, allowing families to develop care plans that meet their preferences, providing information about care in the community so they can make an informed decision, and clarifying for families and caregivers about their freedom to pick provider of choice, and a coverage for that post-acute care.

It's also important to provide them with information, that they have a contact within the hospital while they're being bumped from place to place, and their right to appeal their discharge or

complaint about the quality of care.

This is particularly important, since surveys from the joint commission were suspended during COVID.

This has been a wake-up call for health and disaster planning.

There's -- it's a time where it's been -- really been -- a time there's been an insidious drift away from community-based planning, to top-down planning.

That's why the governor abandoned the modus operandi, and called upon hospitals to work together.

We believe it's time to go back to the future and establish regional health-care planning, like what we used to use during the health-systems agencies.

It's also -- we also recommend that more consumer representation is needed on the Public Health and Health Planning Council, and that CON reviews need to be expanded to include the attorney general when mergers and consolidations and sales are involved.

We strongly support the Community Voices for Health Systems Accountability, who is calling for

the cessation of hospital closures and mergers, and the need for community-impact assessments. We need to engage the community in health-care planning.

Disaster plans need to be functions-based and have a whole community perspective.

And those are disaster-planning terminologies. And there are great frameworks out there that, in part, New York State helped develop, that are available to help walk states through how to do this.

In closing:

We want to thank you for narrowing the waiver of liability for hospitals.

Really, the ability to register quality-of-care complaints, and seek legal measures, to address poor care are critical parts of this system of checks and balances.

And we look forward to working with you to create solutions and action, rather than blame and excuses.

And thank you for your work here today.

SENATOR RIVERA: Thank you so much for testimony.

Now the Assembly will lead us off.

ASSEMBLYMEMBER MCDONALD: We'll start with

our health chair, Mr. Richard Gottfried, 5 minutes.

ASSEMBLYMEMBER GOTTFRIED: Okay.

A question for Ms. Barlow.

On the question of a person who has their own ventilator, are you saying that the guidelines contemplate taking that person's ventilator away, and leaving them lying there without a ventilator?

Or is the issue that their ventilator would be part of a pool, and the ventilator that they use might be a different one from the one they brought with them?

JESSICA BARLOW: So, kind of both.

So, first of all, it is fairly common, in my understanding, that if a chronic ventilator user goes to a hospital during a non-rationing period, it's very likely that they would be transferred to a hospital ventilator as opposed to their own personal ventilator.

The reason we usually hear for that, is that the hospital staff is trained to use a particular type of ventilator. And for liability reasons, they don't want to be messing with someone's personal ventilator.

But the first part of your question is true in a ventilator-rationing situation.

Should a person who's a chronic ventilator user enter an acute-care facility, an emergency room, during a rationing period, and their ventilator becomes fair game for the pool of ventilators.

And so the triage procedures are used to determine whether someone else is more deserving, is more entitled, under those triage procedures, to that ventilator.

So it is, essentially, no longer that person's property. It becomes a ventilator in the pool, to be reallocated to someone else, which could, if there are not enough ventilators, leave the individual who entered with the ventilator without a ventilator at all.

ASSEMBLYMEMBER GOTTFRIED: I think it would be helpful if -- certainly to me, if you and Catherine Hanssens and anyone else could identify exactly where that language is in the guidelines, or anything else, because I haven't -- I haven't seen it. And it's -- it strikes me as not the sort of thing I ever have seen in New York law.

So I think if you can point to that language, and not just say, "well, it's in the book," but show us where in the book that is, that would be helpful.

And do you think if -- if a hospital's personnel feel that they are untrained in using a particular variety of ventilator, but are trained in using a different, I don't know, brand that does, essentially, the same thing, is that a problem?

Wouldn't you want the hospital staff using the equipment that they have been trained on and know how to work?

JESSICA BARLOW: [Indiscernible] the first -- to your first point, I would be glad to have my office send over the guidelines with the particular portions that we believe state that a personal ventilator can be reallocated, highlighted.

Or, I can point to it here. I'm not sure -- everyone probably doesn't have the guidelines in front of them, so it probably wouldn't be helpful for me to share page numbers right now.

ASSEMBLYMEMBER GOTTFRIED: [Inaudible] where to find it.

JESSICA BARLOW: But regarding training with ventilators, it's my understanding that -- and I am not a medical professional, I'm an attorney -- so it's my understanding that, generally, most medical professionals could use, basically, any type of typical ventilator, besides, maybe, a homemade one,

which is something that the ventilator community is actually working on, coming up with their own, so, in rationing situations, they would have something to work with.

But it's -- it's -- from what we've heard, hospitals tend to have a preference in a best-case scenario, where we're not in a rationing situation, that this is the one they're most familiar with.

But I would imagine that probably goes for a lot of different types of medical equipment, in that this is what our hospital uses, this is the brand we use, this is the particular device that our hospital has.

But, in a situation where doctors and nurses are volunteering at other hospitals, or traveling, it is my understanding that, generally, they can use other types. But, if there's a preference, and that opportunity is there to choose, that they would choose the one that they have the most experience with.

ASSEMBLYMEMBER GOTTFRIED: Okay.

CATHERINE HANSSENS: Yeah, if I could just add, I don't -- the issue is not -- the issue is more, there were six patients in need of a ventilator, and five ventilators, including one that

was brought in by a patient, how is the decision going to be made?

And it's not an unprecedented problem.

I think there was a --

SENATOR RIVERA: If could you finish your thought, ma'am, since the time has expired.

CATHERINE HANSSENS: Oh, okay.

I'll stop right there.

ASSEMBLYMEMBER GOTTFRIED: Okay, but you will both point out for us in this guidebook where the language is that concerns you?

CATHERINE HANSSENS: The guidelines are extraordinarily long, even though they deal only with ventilator access. So it's understandable you might not have seen it.

But, absolutely.

SENATOR RIVERA: I'll start -- I'll start my time.

I'll recognize myself for 5 minutes, and say that, on behalf of my colleague Dick Gottfried, you just -- you -- you -- tell them, no matter how long it is, he will go and he'll look through it.

So please let us know where those -- where those guidelines are so that we can look through. And if there's something we need to change, then we

will do so.

My question is for Mr. Harazin, actually.

The -- is that correct pronunciation of your name, first of all?

MARCUS HARAZIN: Yes, that's correct.

SENATOR RIVERA: Okay.

So you spoke about, I believe, certificate-of-need process, and your suggestion that the attorney general be brought into the process.

Could you tell me a little bit more about what you mean by that?

MARCUS HARAZIN: Well, in other states -- in many other states.

Other agencies are involved here in New York who really don't do that.

But when you're talking about the types of mergers and consolidations that are continuously going on, it's really important to kind of look at the overall picture in terms of the character, competency, and the financial connections, and possible conflicts of interests that are involved in these changes, and where we're going.

And I think you probably heard a little bit about that in the other hearing, about nursing home

mergers and privatization.

We're headed in a direction where, you know, we're getting the massive consolidation of health care.

I don't need to tell you that, but the communities are not well-served.

So the attorney general's office could do that type of research and look at the possible legal ramifications, you know. And I think their involvement is important.

SENATOR RIVERA: Is that something that you folks have been calling for for a while?

MARCUS HARAZIN: Oh, yeah, yeah.

SENATOR RIVERA: Okay, because it must be -- I have not -- I do not remember having this conversation about this particular, the -- this -- I've had many conversations about certificate-of-need process, but I've never had one specifically that relates to the inclusion of the attorney general.

You're saying that there's are other states in which this is a model?

MARCUS HARAZIN: Yeah.

And we would be happy to kind of, you know, work with some of the other advocacy groups, to kind

look at that, and provide some recommendations on how a better process can occur.

SENATOR RIVERA: Please do.

And because the -- and last question on this topic:

You -- you -- so you've obviously -- as you said, you have been trying to get this done for a while, or you've advocated for it for a while.

Has there been vocal resistance?

Has there been --

MARCUS HARAZIN: I think this, the whole planning process, now, you know, frankly, is so top-down, that it's very hard to -- you know, to break in.

And I think we know that, a good example is, the Hospital and Health Planning Council, which was meeting today during the day of your hearing, I mean, to talk about hospitals during COVID.

SENATOR RIVERA: Timely.

MARCUS HARAZIN: Yeah, very timely.

But that's just a great example.

We need to have more consumer input there, we need to kind of break it down on a regional basis, and we need to kind of make the process more oriented toward community need rather than, you

know, corporate need.

SENATOR RIVERA: Got you.

Thank you so much.

I'm not sure if either of you ladies want to comment on this issue?

CATHERINE HANSSENS: I don't have anything to add.

SENATOR RIVERA: All right.

Thank you so much.

That is my time.

Back to the Assembly.

ASSEMBLYMEMBER MCDONALD: And I actually have a question about the ventilator, but I'm also smart enough to know that two other hands are raised that might know more, and I'll learn something.

So we're going go to Missy Miller, for 3 minutes.

ASSEMBLYMEMBER MILLER: Hi.

Thank you so much.

It's very interesting that we're discussing this because, back at the end of March, I actually wrote a letter to Dr. Zucker, department of health, as well as the attorney general, with a copy of those ventilator guidelines, because I was hearing, you know, a tremendous amount of concern

from the disability community over these guidelines.

I never did hear from Dr. Zucker, but I was assured by the governor's office that there was absolutely no need for concern; that they would never ration or, you know, take away a ventilator from a person in need, simply based on their evaluation versus a neurotypical or a more physically-robust individual.

That that -- that -- that comparison that the guidelines reference, very clearly, that there is no such thing. That it would be against the Americans with Disabilities Act.

And -- so I was -- I was verbally assured that that does not happen, but I never did receive any response or reply to my letter to Dr. Zucker or the attorney general.

And, Dick, I'll send you, I have the guidelines right here. I'm going to e-mail them to you right now.

ASSEMBLYMEMBER GOTTFRIED: Thank you.

CATHERINE HANSSENS: Well, I mean, it's interesting because, our agency, along with Treatment Action Group, The National Age Treatment Network, Callen-Lorde, [indiscernible], and a variety of other organizations, also sent a letter

to Commissioner Zucker, the governor, and several other state leaders, and we got no response whatsoever, about exactly that issue.

And, also, I mean, the other problem is -- the problem is not -- there are many good things in the guidelines. The guidelines are not across-the-board horrible.

But there are -- there is the issue that Jessica described in detail, and, also the fact, as I mentioned earlier, there are a variety of emergency services, other than ventilator access, which are not addressed.

And, as has been reported several times since the pandemic started, line physicians are being asked, or being told, that they will need to make decisions about who does and doesn't get care, without any kind of uniform guidance.

And -- which is a --

ASSEMBLYMEMBER MILLER: Well, [indiscernible cross-talking] --

CATHERINE HANSSENS: -- other than an unfair burden [indiscernible cross-talking] --

ASSEMBLYMEMBER MILLER: -- triage the people who would have the better outcomes.

CATHERINE HANSSENS: Well, that should be --

ASSEMBLYMEMBER MILLER: [Indiscernible cross-talking] have a person who has a physical disability, or, you know, underlying, they don't have that rosie outcome as somebody who's just, you know, healthy with an acute condition.

MARCUS HARAZIN: Well, and that depends on how you define the length and nature of a "rosie outcome."

If -- the decision should be based on whether or not somebody is going to benefit from that intervention. Not whether, looking at them as a person who may be missing a leg because of diabetes, the quality of their life, or the long-term expectation because they've had perhaps HIV for 25 years, is factored into that decision, which is why [indiscernible cross-talking] --

SENATOR RIVERA: Thank you.

Thank you, Ms. Hanssen.

CATHERINE HANSSENS: -- people are concerned.

SENATOR RIVERA: Thank you, Ms. Hanssen.

CATHERINE HANSSENS: You're welcome.

SENATOR RIVERA: Thank you.

Assemblymember, currently, no members of the Senate to ask questions.

Back to the Assembly.

ASSEMBLYMEMBER MCDONALD: We will continue my theory of asking smarter people to ask questions than I, and that would be John Salka, for 3 minutes, who actually practices in the respiratory-therapy field.

ASSEMBLYMEMBER SALKA: Thank you, John. I appreciate that, and I appreciate the time.

And I appreciate the testimony of this panel.

This is a question for Ms. Barlow.

If someone does come in and they're ventilator-dependent, and they have the home ventilator, and it's taken away to put into a pool, if that particular person's status is not DNR, which is a "do not resuscitate," isn't the hospital committed -- just in case that person invariably goes into respiratory failure, isn't the hospital committed to start resuscitation proceedings -- procedures on that patient?

JESSICA BARLOW: Yes, I --

ASSEMBLYMEMBER SALKA: They get their ventilator taken away, they go into respiratory arrest, they're not a DNR, isn't the hospital committed to have full measures of resuscitation applied to that patient?

JESSICA BARLOW: Yes, but in that case, the

hospital is the reason that that person is going into respiratory distress. They extubated a person, who's ventilator-dependent, from their personal ventilator.

You wouldn't take a diabetic's insulin away from them and say, well, this person deserves it more in this situation.

This is someone's personal medical device, and they're dependent on it.

And the hospital, creating a more emergent situation, and then fixing that situation, I don't think that they should necessarily be praised for that, though I certainly don't blame hospitals who are following these guidelines.

Like I mentioned, they don't have anything else to go on at this point.

ASSEMBLYMEMBER SALKA: I agree.

And coming from the perspective of a respiratory therapist, these are incredibly complicated machines, pieces of medical equipment.

And unless you have a thorough orientation to a different -- or, a particular type of ventilator, I don't know of any clinician, at least that holds a license in New York State, that would chance trying to run something that they haven't been thoroughly

acquainted with.

So to put these ventilators into a pool, and not orient those who are going to be running the -- this particular piece of equipment, is a recipe for disaster.

And, personally, I would refuse to do it.

So it's something that I think is unrealistic to expect a medical professional to do.

And to ask a clinician to play God, by taking a ventilator away from someone who is ventilator-dependent, is just -- it's -- that's -- that's just -- that's just wrong. That's just absolutely wrong.

And I'm looking forward to reading guidelines myself, so that I can relay this to other professionals -- other health-care professionals that I know.

And thank you very much for your time.

JESSICA BARLOW: Thank you.

ASSEMBLYMEMBER MCDONALD: And I will just close with my own comments on this issue, if it's okay with you, Senator Rivera?

SENATOR RIVERA: Indeed it is.

ASSEMBLYMEMBER MCDONALD: Jessica, I -- thank you for bringing this up.

As I'm listening to this, I'm saying, well, wait a minute.

This is more than likely -- first of all, these ventilators you just don't get off the shelf.

They're not cheap. They are an individual's personal property. Their insurance probably paid for it.

And as John pointed out, very well, is that clinicians don't like to jump to other pieces of equipment, particularly if they're not familiar with it.

It's not in the best interests of anybody; number one, the patient; and, of course, the clinician; and then, of course, the organization.

So I just want to say thank you for bringing this up.

Missy, I know you're going to send those guidelines to Richard.

And I'd hope you share them with me as well, because I just find it hard to believe that, although I recognize there could be a crisis, that people's personal property would be taken away from them at a moment when they're in desperate need.

And with that, I will cease my comments, and thank the panel for their participation today.

SENATOR RIVERA: I will echo those thanks, and wish you a very good rest of your day.

As we --

ASSEMBLYMEMBER GOTTFRIED: Senator?

SENATOR RIVERA: Yes.

ASSEMBLYMEMBER GOTTFRIED: I would just like to stress, the guidelines document is a very thick book.

And I just want to reiterate what I said earlier: If you just say, well, here's the book, it's in there somewhere, that's not going to do me any good.

What I need people to do is say, look on page 28, about halfway down the page. That's where the paragraph is that concerns us.

JESSICA BARLOW: I could point you to pages 5 and 6, and pages 40 through 42.

Those are the pages that we cited in our OCR complaint.

So, just off the top of my head now, those would be the most relevant.

ASSEMBLYMEMBER GOTTFRIED: Put that in an e-mail to me.

JESSICA BARLOW: Sure. Absolutely.

SENATOR RIVERA: You got a second round

there, Dick. Doesn't usually happen.

ASSEMBLYMEMBER MCDONALD: Oh, well, been here 50 years, you get a little benefit once in a while.

Thank you, folks.

Now we move on to our last, but certainly not least, panel, and that is:

Dr. Erik Larsen, assistant director of EMS and emergency preparedness for the White Plains Hospital;

Dr. Miao Jenny Hua --

I hope that I to pronounced your name correctly.

-- a doctor in New York, New York;

And, Janet Menendez, a resident of Morningside Heights, New York.

ASSEMBLYMEMBER GOTTFRIED: And, for the last time in this hearing, do each of you swear or affirm that the testimony you are about to give is true?

DR. MIAN JENNY HUA: I affirm.

JANET MENDEZ: Yes.

ASSEMBLYMEMBER GOTTFRIED: Okay. Thank you.

SENATOR RIVERA: Ms. Mendez, and, do we have Dr. Erik Larsen?

ASSEMBLYMEMBER MCDONALD: He's listed. I just don't see him yet.

SENATOR RIVERA: I don't see him.

Since I'm not seeing him, I will --

OFF-CAMERA TECHNICIAN: He's working on turning on his video.

SENATOR RIVERA: Okay.

Dr. Hua, why don't you lead us off.

DR. MIAN JENNY HUA: Sure.

Thank you, committee members, for the opportunity to speak.

I'm here representing myself, although, through the months of February to June, I worked as a resident physician in the internal medicine department at Mount Sinai Hospital on the upper east side of Manhattan.

As a front-line physician, I was working 12-hour shifts, 7 days a week, every other week, on the COVID-19 ward, while the City was reporting 5,000-plus new cases and 600-plus deaths from COVID every day.

This experience taught me one key lesson:

Hospitals, the majority of them private, did not respond to the pandemic as if it were their task to suppress it.

Existing inequities were magnified as a result.

As Governor Cuomo congratulated his constituents about bending the curve and preserving the health-care infrastructure, the unmentioned cost was the record-shattering death toll.

Over two months in spring, New York City's COVID-19 death toll exceeded that of the 1918 flu outbreak.

The preservation of the infrastructure thus came at the expense of human lives.

According to data from the New York City Department of Health and Mental Hygiene, only around 26 percent of COVID-19 patients were hospitalized at the peak of the initial surge in early April.

In late April, when I was working in the emergency department at Mount Sinai, most patients symptomatic with COVID-19 were still being turned away even when they tested positive.

This included many among the old and frail at high risk of dying, but did not show a low oxygen saturation level at the time of presentation.

Stringent admission criteria is a holdover from pre-pandemic practices.

We can see from federal data that, over the past 20 years, the number of emergency department visits has steadily risen, even though the

percentage of those visits leading to an admission have declined. But there's a huge problem with hospitalizing the bare minimum in the midst of a pandemic when not limited to the individual lives at stake.

Sending patients back into the community assumes from the outset that hospitals have no role in interrupting the virus's chain of transmission.

Because the negative COVID-19 was not necessary for discharge in New York, many patients leaving the hospital returned to endanger those close to them in their community, with devastating consequences, especially in nursing homes and low-income communities of color.

The contrasting measures taken at Wuhan are instructive.

Three years ago I lived in Wuhan, doing research as a medical anthropologist, at a hospital that would go on to become the largest coronavirus treatment center in China.

According to local government data that my contact sent me, by late February, hospital capacity in Wuhan had expanded enough so that 95 percent of all COVID-19 patients were hospitalized.

This number is concordant with research data

that the U.S. CDC cites from China.

COVID-19 patients in New York were sicker when they were admitted, and only 26 percent were admitted, and spent less time in the hospital compared to their counterparts in China, where the medium length of hospital stay was around 10 days, in comparison, in New York, COVID patients were discharged after a median of 4 days.

As we know, since late March, there have been no new cases of COVID reported in Wuhan.

In fact, I think the peak of the -- at the peak of the pandemic, there was a surplus of beds in some hospitals around New York City. And Mount Sinai Hospital on the upper east side was one of them.

During April, I remember walking through hundreds of empty beds in the lobby before starting my 12-hour shift on the COVID ward. These beds were set up in anticipation of an even bigger surge of patients that never came.

At the same time, Black and Brown patients who flocked to public hospitals in Bronx and Queens died in disproportionate numbers.

We know this well.

Colleagues of mine, who had the misfortune of

being assigned to work at Elmhurst, recall having to take care of dozens of COVID patients who would all be dead within days.

One resident admitted eight patients from the emergency department overnight, to have four die by the morning.

So this is the biggest problem: The hospitals in New York have not responded to the pandemic as if it were their task to suppress it.

Ignorance is no excuse.

By mid-February, I was speaking personally with leaders at Mount Sinai Health System about the necessity of preparing for the pandemic, referring them to my contacts at Wuhan for front-line expertise.

They did not take me up on my offer, even though they told me that they expected the coronavirus to enter into endemic transmission.

In other words, hospital leaders were fully expecting that the virus would not be contained.

Instead of training front-line staff immediately on PPE precautions and infection-control protocols, hospital leaders' response was to downplay supply shortages.

Instead of operating as an essential layer of

a public-health infrastructure, hospitals acted like businesses trying to control costs, and the government did not step in to tell them to act any otherwise.

The consequence has been disastrous by every meaningful metric.

Thank you.

SENATOR RIVERA: Thank you so much, Doctor.

Followed by Dr. Erik Larsen, assistant director of EMS and emergency preparedness at White Plains Hospital.

DR. ERIK LARSEN: Okay.

Hello, and thank you for inviting me to this hearing.

First of all, I just want to say, my comments are not the official line of the -- or, I'm not officially representing White Plains Hospital.

I am also a chief medical officer for HHS, the assistant secretary for preparedness and response. And I've done disaster response for 30 years, including a number of major disasters, including "Hurricane Katrina," earthquakes in Pakistan, and Haiti.

And I'm going to talk about two things today.

I want to focus on EMS (emergency medical

services), which I think is a key part of the whole hospital system, and the fact that EMS has never really been considered, right from the beginning, the third uniform service, along with police and fire. It's never gotten that type of support.

And it is a mish-mash of volunteers, paid private services, some public municipalities, and you know, big systems, like New York City, which is a public entity.

So because of that, it's the poor stepchild.

So these agencies, unfortunately, we're not equipped with PPE. They had to get it themselves.

They were not appropriately trained because it costs money and time to train people.

And so, for this reason, many of the -- in the early parts of this pandemic, the EMS folks took a heavy hit. And I saw a number of our services in the area of White Plains.

We were, actually, sort of ground zero for the pandemic in New York State, in that the first patients appeared here in early March.

So, anyway, with that being said, it is very important that EMS gets supported. That we -- it's not even mandated in New York State that a town needs to have EMS.

They have to have fire, they have to have police, they have to have sanitation, they have to have a highway department.

You do not have to have EMS. There's nothing about that.

So, unfortunately, they are the poor stepchild.

So, we need to really support them because they are key in the hospital system. They bring patients to the hospital who are in acute distress, and they do all this transferring that folks have been talking about throughout the hearings today.

The second thing I'd like to talk about is acute -- the -- the alternative care centers.

So we were involved in the alternative care center here in Westchester.

Suddenly, we start to see at the end of March, it was March 27th, I happened to drive by and noticed that they were rebuilding the Westchester County Center, and, all of a sudden, these structures were going up.

There had been no consultation whatsoever, that I know of, between the department of health -- the local department of health here, EMS agencies, departments of emergency service agencies in

Westchester County, any of the hospitals, any of the hospital administrators, myself, and a number of other local experts, about consulting on whether to build this alternative care center.

So they went ahead, started building this, what was -- I was told, is -- was a 30-million-dollar project in the Westchester County Center, which included three tent -- four tents, and an inside structure, that were supposed to be ICU-capable.

Who made that decision?

Who decided what the needs were?

It was very unclear to me.

One thing that was very clear was, although they were building this 30-million-dollar project, one of the things -- the only thing we knew about COVID back then for sure, that we all agreed on, is that everyone needed oxygen.

And here we were going to build an ICU-capable unit that was not even going to have a central oxygen supply.

So I got involved, and probably added another $5 million, when I said, we need to add, basically, liquid oxygen, the same types of systems that hospitals have.

So the other thing that was key was, it was never clear who was going to staff these. Okay?

And so the question of volunteers came forward in this volunteer list.

We tried to make sense out of the volunteer list. We tried to go through the volunteer list and pick people out.

There were a number of key things that were never answered:

Who was going to staff it?

Whether people are going to get paid; whether they're not going to get paid.

Who was going to cover malpractice for them?

More importantly, who was going to cover workman's [sic] compensation, should they get hurt, or get COVID, most likely?

How were they were going to be [indiscernible].

All these type of questions were never answered for us.

And, luckily, we plateaued, and, basically, these facilities were being -- have -- were shut down and mothballed.

So what we really need is a clear understanding of what these missions are -- you

know, what these alternative care centers are supposed to be, who's supposed to staff them, and how we were going to supply them, all the ancillary wraparound services.

All that type of [indiscernible] was never answered.

SENATOR RIVERA: Thank you, Mr. Larsen.

And last, but certainly not least, we are joined by Janet Menendez, resident of Morningside Heights.

Good afternoon, Ms. Mendez.

Go ahead.

JANET MENDEZ: Thank you, Senator and Assemblymember, for the opportunity to testify.

My name is Janet Menendez, and I'll be testifying on my experience as a COVID-19 survivor, treated at Mount Sinai's Morning Height [sic] Hospital.

On March 25th I was hospitalized at Mount Sinai Hospital after having worsening COVID-19 symptoms for two days.

At the time, tests was not publicly available.

Upon admission to the emergency room, I tested positive for the virus, and for pneumonia.

Within just an hour, I was put on a ventilator and induced into a coma that lasted over two weeks.

While in intensive care, my family authorized the use of trial drugs and several options doctor recommended to them.

I was discharged on April 19 -- I mean, April 13, making the totality of my hospital stay 19 days.

Only a day after I was discharged, I began receiving calls, asking how I was going to pay for the care that I just received.

I then also began to receive several bills in the mail.

My first bill I received was in the amount of $31,000.

However, because I could not work due to my immobility, I decided to try to focus on my recovery rather than on the medical bills.

The next bill, however, was too large to ignore.

I received a bill of $401,000, with the hospital financial assistant [sic] benefit of $326,000, and that still left me with more than $75,000 to cover on my own.

In the coming weeks I received several additional bills, ranging from $40 to $1,000.

I also had several different departments calling me, with little to no details on specific procedures being charged for -- for the totality of my medical debt.

On the bill [indiscernible] it read, "medical cardio care," with different charges, ranging from 41,000 to 82,000 dollars, or, pharmacies, for another $42, with no breakdown of what medical -- what medicines I received and how much each cost.

I obviously will not know the type of procedures being charged for because I was unconscious for the majority of my hospital stay.

After receiving several medical bills, I contacted Community Service Society, who helped me determine what my employer insurer was still active, and Mount Sinai did not have the correct insurance information.

As a result of this, I was being charged as if I was uninsured and, thus, sending me bills directly.

This entire process has been confusing, because even though I am covered by my insurance plans, I still have so many additional charges that

discourage me from receiving care.

Although this means that I'm in the process of fighting the charges alongside with CSS, I am still responsible for the annual out-of-pocket maximum contribution for network care, which is $10,000.

It is still difficult for me to understand how a person like myself, who has worked mostly paycheck to paycheck in the hospitality industry, will be able to pay off this debt, especially in the middle of a pandemic that has caused so much unemployment and loss.

I was at least lucky enough to have my insurance coverage plan overlap with my hospital stay.

But many others who have lost their coverage due to the unemployment, or those who not even qualify for health insurance because of their immigration status, this makes me lose confidence in the actions of this state.

We have to be bold, and continue to push for expansion of health-care options for undocuments [sic], reform medical-bill practice, and, ultimately, create a single-payer system in New York State so that the health-care decisions are

not driven by the ability to pay.

Thank you.

SENATOR RIVERA: Thank you, Ms. Mendez.

I will be leading off questioning, I recognize myself for 5 minutes.

Well, Ms. Menendez, I will tell you, obviously, I'm very happy to see you, although we've not met in person.

For full disclosure, Miss Menendez is the sister of one of my staffers. And we are so happy to see you healthy, and, kicking ass.

So thank you so much for being here and sharing your experience with us.

You -- so at this moment, you have -- there's still an outstanding bill of about $75,000 that you say that you have, that you are responsible for, according to the hospital?

JANET MENDEZ: Well, when they sent me the bill for 75,000, it was when they believed I didn't have health insurance.

SENATOR RIVERA: Okay.

JANET MENDEZ: So after once, I called the hospital and gave my medical insurance. They processed it, but because the way they -- Mount Sinai bills, they go by different departments.

So those send me one bill. Then they'll send me another bill. And then another bill will say, oh no, I didn't have your insurance, or, I had the wrong number, or, I have the wrong social. And then the process will start all over again.

SENATOR RIVERA: And this is -- and this was -- and this was while you were recovering, after being -- after spending two weeks in a coma, and then 19 extra days.

How much longer were you in the hospital after you came out of the coma?

JANET MENDEZ: I believe like a week and a half.

SENATOR RIVERA: Like a week and a half.

So you were convalescing, obviously, recovering from this.

And you have -- and I know because my staffer, obviously, is incredibly smart, and, obviously, loves you very much.

And she had to spend all sorts of time on the phone, trying to clarify a lot of this stuff.

Do you feel that -- let's say that the situation was different, and it's possible for many other people who are not here today, who do not have someone like a family member who is -- who has the

ability and the time to be able to go and make all these calls, and everything.

How do you feel -- do you feel that those folks are being protected right now?

JANET MENDEZ: They're not, because the reason why I keep doing the interviews, I keep pushing my name around, is so that people that don't have the knowledge or don't have the help like I do with my sister, could get some information and fight for this.

We're supposed to be receiving so much help.

Where's this help?

Where was this promise that we didn't have to pay for hospitals if we got COVID?

So why are they sending me a bill so high?

So imagine if a person with a single home, that are singles, they have to pay, because most of them don't have insurance because it's really expensive.

So they don't have insurance, and now they're stuck with this bill.

When are they going to pay?

Now they're in debt. They're probably college students, they have college debt.

And this debt keeps getting bigger and

bigger.

So when are -- when are they going to help us? How do they expect us to pay?

SENATOR RIVERA: Got you.

So -- and -- and I should say that there is -- there is a piece of legislation -- or, pieces of legislation that we have started, that my colleague and I in the Assembly, we're trying to push, to make sure that we can actually address this and resolve this.

Thank you so for bringing your experience.

Ms. -- Dr. Larsen, I wanted to just, for the end here, when you -- your discussed the situation when there was -- in Westchester, there was a -- there was this -- this thing that was -- that -- this center that was put up very, very quickly because they were kind of -- they thought that they might need it.

Ultimately, it was not needed, which is obviously a good thing.

But your concern about their lack of outreach, meaning the State, do you feel that your involvement -- because you say that you weren't involved before, but you eventually got involved because you said, you're going to need oxygen, so

you're going to need to spend this extra money to make sure that it's ready to -- if you're going to use it, it needs to have oxygen.

Do you feel that that involvement may have changed the way that the State does it in the future, since we're talking about what we can do, going forward, if such a situation were to happen again?

DR. ERIK LARSEN: Well, I would hope so.

You know, again, the whole question, I mean, the Army Corps of Engineers was the, you know, building agency. They had subcontracted this.

Look, they did a record job of creating something like this.

But the question was, why wasn't the medical community consulted?

CEOs of hospitals weren't consulted. Doctors, nurses, folks, were not consulted about this.

For instance, here's a hospital in Mount Vernon, and I think people talked about it in earlier testimony, that, basically, is being closed down; a hospital structure, with everything intact, that, if they had taken --

SENATOR RIVERA: There was no discussion

about using Mount Vernon Hospital in their excess capacity, perhaps, since it was there?

DR. ERIK LARSEN: Not to my knowledge, and I've explored this.

I know hospital administrators, you know, had raised this. Multiple people had raised this issue.

And here they were, building a -- you know, first of all, taking a public building in the county that may or may not need to be used in the future, building a tented structure.

It was all very well put together, although, like I said, here this was built to be an ICU-capable facility, had people on ventilators -- would have people on ventilators, but had no oxygen supply.

SENATOR RIVERA: Thank you, sir; thank you, Dr. Larsen.

That's my time.

Back to the Assembly.

We will move to our chairman of the health committee, Richard Gottfried, for 5 minutes.

ASSEMBLYMEMBER GOTTFRIED: Thank you.

Quick question for Janet Menendez.

The 10,000 that you said you were responsible for, I didn't catch, was that because Mount Sinai

was in-network or not in-network.

JANET MENDEZ: So the -- we're still fighting with the charges, because a lot of the cardiologist charges were put out-of-network.

So we're fighting that, putting them in-network.

But the 10,000 is my out-of-pocket deductible that I have to pay with insurance that I have.

ASSEMBLYMEMBER GOTTFRIED: Okay.

All right. Thank you.

And for Dr. Hua, I'm not sure what public policy you're suggesting we adopt.

If someone shows up at an emergency room with symptoms of COVID-19, what should that hospital be required to do at that point?

Because you said many of those patients would just be sent home.

Should something different be done; what would that be?

DR. MIAN JENNY HUA: Thank you for the question.

So I'm not in the position to offer prescriptive guidelines, because I think these guidelines actually take a lot of expert deliberation to come up with.

However, one of the chief problems is that, there was no such guidelines to -- there were rules of thumb, in other words, that operated to, basically, whether someone had to be saturated to such an extent that they would need supplemental oxygen for an extended period of time.

Sometimes if they'd be saturated, but did not have an oxygen saturation below 90 percent, they were still deemed safe to go home.

And we know that, eventually, there were lots of deaths at home reported because patients did not de-saturate either at the time when they presented in the emergency room, and later on, because of [indiscernible] injury to their heart, had some kind of an arrhythmia, and passed away that way.

So there was definitely under-admission due to the fact that people were using the most basic sort of rudimentary objective, but not necessarily sensitive, admission criteria for patients.

And so, you know, in terms of the individual lives at stake, I think many lives were lost that way.

On the other hand, there is also the issue of just enforcing, or at least giving people the opportunity to engage in self-isolation and

self-quarantine, which many patients did not really have adequate, a safe, stable location in place, especially patients already experiencing unstable housing.

You know, I admitted patients from the emergency room who went in and out of quarantine somewhere upstate in a hotel, and there was nobody to really tell him to stay in quarantine.

And I know even -- I think now, with the contact-tracing program, there's not a sufficient logistical consideration for how people who test positive ought to separate themselves from their loved ones.

And also -- so I think, you know, obviously, the makeshift hospitals, the field hospitals, whether it's the Javits Center or Billie Jean King, could have been utilized a lot better. We know their initial criteria was far too stringent in the beginning of April.

So I think there are countless policy options in terms of how to better utilize space, especially for patients who were relatively asymptomatic.

I think we were kind of lulled into a false sense of security with the 80/20 breakdown, in terms of 80 percent having, basically, no symptoms, or

minimal symptoms, but, you know, with a disease that we know so little about, even to this day.

And, also, in the period when it was so possible to contain the pandemic by actually suppressing the number of cases and the number of transmissions, I think we really missed an opportunity.

ASSEMBLYMEMBER GOTTFRIED: From your description of Wuhan, it strikes me that they didn't have guidelines to apply either, except, if you show up with what looks like COVID, we lock you up.

DR. MIAN JENNY HUA: Well, that's -- I would correct that.

ASSEMBLYMEMBER GOTTFRIED: [Indiscernible.]

DR. MIAN JENNY HUA: Yeah, right.

So, that's not entirely true.

So I would have to look back, but, at some point, it was the state council. So there was much more nationwide guidance.

So the state council issued clinical guidelines. It's not something I would expect the U.S. to be able to implement.

But they actually did guidelines, and, yes, they were much more aggressive about implementing lockdown measures.

But, of course, there are many alternatives to that.

Japan, for instance, have a mandatory hospitalization policy without the similar level of stringency or, you know, draconian enforcement involved.

ASSEMBLYMEMBER GOTTFRIED: Do you know anything about other countries; Taiwan, South Korea --

DR. MIAN JENNY HUA: Well -- so -- yeah, so I think this is going to be an ongoing conversation, and the time is up.

But -- so I'm not sure about their hospitalization policy, but I don't think they really had that many cases.

Taiwan, for example, really didn't have that many cases for it to be a huge issue. I think they were fully capable of hospitalizing everybody who's infected.

ASSEMBLYMEMBER GOTTFRIED: Got you.

Thank you, Doctor.

SENATOR RIVERA: Thank you, Assemblymember.

ASSEMBLYMEMBER GOTTFRIED: Okay. Thank you.

SENATOR RIVERA: Recognizing Senator James Skoufis for 5 minutes.

SENATOR SKOUFIS: Thanks very much.

And thanks to each of you, especially our patients waiting till the evening to speak with us.

Dr. Hua, you're obviously -- you're critical of the lack of preparedness that existed here at hospitals, especially, you mentioned training, you mentioned PPE procurement.

Given what was happening in the weeks and months ahead of the virus getting here, in places like Wuhan, if you can look into your crystal ball, can you give a sense of, you know, if we did pay better attention, if we did prepare to the extent practicable, what the world would have looked like in New York, in lieu of what actually did happen over the past five months?

DR. MIAN JENNY HUA: Thank you for the question.

I think if everything sort of -- everything that you want to be in place, all of the well-formed plans, we know there were drills since 2009 -- I think Commissioner Zucker was reporting on that this morning -- that was supposed to prepare New York City for the kind of crisis that we saw with the coronavirus, if all those plans had, indeed, done what they were supposed to do, we

should be able to have a situation where we have a few dozen cases a day.

What we see in a lot of European cities, where the curve really has bended to the point that -- you know, we have seen that in New York, so let me correct myself, that it's a national issue that kind of expands beyond the borders of New York.

But I think, you know, the death toll in Wuhan, for instance, they had 30,000 cases, 4,000 deaths.

So the death toll in New York is many times that. It's, twenty, thirty thousand.

So I think that is really one of my major concerns in terms of a second surge. You know, no one can say, but I think we have to be on guard for that.

And I know that kind of exceeds the jurisdiction of municipal and state government.

But, nationally, we can certainly, you know, picture a very different scenario.

SENATOR SKOUFIS: Sure.

And do you have faith that, if a second wave is awaiting us in a few months, or, quite frankly, the next pandemic a year from now, five years from now, whenever it might be, do you have faith that,

in your experience, here in New York, that the lesson was learned, and that the preparedness will be in place, given what transpired over these past five months?

DR. MIAN JENNY HUA: I do not see evidence that the lesson has been learned, insofar as I don't sense that the administration at Mount Sinai Hospital was prepared to evaluate what they did wrong, nor was there really an effort to even talk about this precise issue that I just brought up in front of you, which is, that we really under-admitted, that the hospitals were functioning on an individual-by-individual basis in the midst of a pandemic, when they were supposed to act more as a part of the public-health infrastructure.

There's no notion of what it means for a hospital to act like it's part of a public-health infrastructure. No conversation about equitable distribution of beds, resources, drugs, across the private and public system; ask for PPE supply.

You know, and I think that -- you know, I was part of the effort, with residents, in late March, early April, to start GoFundMe campaigns, to pay for PPE, before Warren Buffet flew in, you know, the PPE supply to Mount Sinai Hospital.

And after that, we've seen a somewhat more stable supply.

But I really, you know, don't see a public-health mandate that affect the hospitals, insofar as they could be mobilized in time for a second surge or for a similar pandemic outbreak.

SENATOR SKOUFIS: I'm curious, have you had these types of conversations with anyone at Mount Sinai on the administration side?

What --

DR. MIAN JENNY HUA: Yes.

SENATOR SKOUFIS: -- what were they --

DR. MIAN JENNY HUA: So I'm -- I've actually resigned from my residency program, so you can maybe gather from that how well the conversations went.

But I was trying to raise alarm, starting with the -- actually, the head of infection control, Dr. Bernard Camins, starting in mid-February.

And actually, you know, spoke with, whether they be, you know, program administrators, program directors, on the issue PPE availability, residents training in terms of PPE.

And it really seemed like, on the one hand, there was this -- you know, there was a disconnect in which, on the one hand, they registered the

dangers of the coronavirus. And that, you know, Dr. Camins told me that this was going to become an issue -- you know, likely going to go into endemic transmission.

But on the other hand, by the time we saw any training or any systemic education on what to do about COVID, it was already sort of in the full swing of the outbreak.

SENATOR SKOUFIS: Mr. Chairman, if I just ask one very brief question to follow up:

Your suggest -- you suggested, Doctor, that -- you already said the conversation didn't go well, you subsequently resigned.

Is the implication there that there was retaliation for --

DR. MIAN JENNY HUA: So I wouldn't go as far as to claim that.

I -- you know, I went as far as writing open letters, and sort of gathering support from my resident colleagues. And I felt a lot of support, actually, from my co-workers and colleagues.

And there was not individualized retaliation per se, but I just felt like all of these gestures were not actually efficacious, or was not accomplishing what I had hoped we would be able to

do.

So that's why I'm kind of outside of the hospital structure, and trying to work within civil society to do something.

SENATOR SKOUFIS: Okay. Thank you again.

SENATOR RIVERA: Thank you, Doctor.

And thank you, Senator.

Assembly.

ASSEMBLYMEMBER MCDONALD: It looks like Assemblymember Tom Abinanti wants to be heard for 3 minutes. A final 3 minutes.

ASSEMBLYMEMBER ABINATI: Here we go.

Thank you.

Thank you all for joining us, especially -- well, it's not 9:00 like the other night, so...

At any rate --

ASSEMBLYMEMBER MCDONALD: Not yet, Tom.

ASSEMBLYMEMBER ABINATI: -- I have a couple of areas that I want to cover quickly.

The first area is: Did more people die than should have died?

We have been talking about, you know, people taking victory laps about what a great job we did, and yet it seems to me an awful lot of people died in New York.

Could we have done something better?

And should we be doing something better in the future?

I'm asking, basically, for a summary of, you know, you kind of touched on this by the questions from my colleagues just before this.

In very simple terms, can you give me a quick answer:

Did too many people die?

Should we have done something different?

And what should we do in the future to make sure this doesn't happen again?

And my second question is something I've been dealing with all day long:

Did we treat people with special needs, with disabilities, with the inability to communicate on their own behalf, advocate on their own, properly during this entire pandemic in the hospitals?

Anybody who wants to respond.

DR. MIAN JENNY HUA: So, I mean, I could sort of take a stab at the question.

So to the first question, I think the simple question is, yes, definitely, more people died than was needed.

We know many people died at home.

Overall death rate was four to six times what you expect, you know, compared to previous seasons, in New York City. And it was a sustained death rate for, you know, multiple weeks, and capacity could have been opened up.

There were many things we could have done differently.

As for how patients were treated on the ground, it's very difficult to say.

But I think, given the restrictions of the pandemic moment, allocation of compassionate care was definitely hindered.

You know, there are no regrets in terms of how I interacted with my own patients.

But I could see how there was burnout among residents. How, you know, people talked about how they really didn't feel like they were providing standard of care, especially at institutions like Elmhurst, in which there were -- because of various shortages, in which people died because standard of care was just not met. So, it was death from negligence.

ASSEMBLYMEMBER ABINATI: Dr. Larsen, do you have a comment?

DR. ERIK LARSEN: Yes, quickly, just that,

look, as an emergency doctor for 30-plus years, look, prevention is always the best route to go.

And you can prevent people, you know, whether it's accident prevention, or whatever.

If we had, as a society, shut things down quick quicker, immediately realized the whole face-mask issue, and really emphasized, through all kinds of [indiscernible] education, the importance of all this, and spent our money there, we could have prevented a lot of the stuff coming into the hospital.

Once you got into the hospital, we were learning about this disease as quickly as we could, by treating it, and also reading whatever primitive literature was starting to come out from the countries that had already dealt with it.

So we were trying to learn.

I'm not sure if we could have corrected things once people made it to the hospital, but we certainly -- and we've learned.

We've learned, and I think the outcomes are better now. And this has been demonstrated around the country, I think.

But the other thing is, is that if we had gotten to the prevention -- preventative measures,

these common basic things, and we had, you know, closed down our society, tightened up, and really educated, we could have prevented a lot of this.

Gotten masks out there, gotten handwashing, you know, education out there; gotten all those kinds of things out there, we could have really prevented a lot of the folks even ever coming to the hospital or ever getting the disease.

SENATOR RIVERA: Thank you, Doctor.

And thank you Assemblymember.

There are no further senators asking questions at the moment.

I believe we have --

ASSEMBLYMEMBER MCDONALD: We have a question from our ranker of Health, Kevin Byrne, 5 minutes.

ASSEMBLYMEMBER BYRNE: Thank you.

I don't think we're going to use the full 5 minutes here, but, I wanted to thank you all, and thank all the previous witnesses for their testimony.

Again, it's been a long week with these legislative hearings, and all your time is extremely valuable to us.

Dr. Larsen, you made some comments regarding EMS.

And one of the things I find interesting is, these hearings are very important.

EMS does kind of fall through the cracks sometimes, and it's not intentional.

That's not a criticism of my colleagues or anything like that, but, where does it fit?

You know, we had a hearing on adult-care facilities. Now we're having a hearing on hospitals.

EMS certainly is a very important part of the health-care system. You're going to and from hospitals, also to and from adult-care facilities, and, yet, maybe we don't talk about it quite enough.

I have to imagine many of the same challenges that our front-line heroes in the hospitals and adult-care facilities had, EMS had as well, including personal protective equipment.

But are there any other specific challenges or things that you could highlight, with the remainder of my time, about EMS, and how we could better equip and plan ahead should there be a second wave?

DR. ERIK LARSEN: Uh, yes.

One of the things that's important is, how we do sort of the -- you know, sort of distributing the

load.

So, you know, EMS systems, if we incorporate some of this, we can try -- and we've got honest participation from the hospital systems, and they can have input and say, look, this is how many patients have arrived, this is how many patients we have on ICU, this is how many patients, you know, we have in ICU beds, on ventilators, in our emergency departments, that we can load-distribute these patients a little bit better, that may be helpful.

But we have to have the support for those ambulances to, you know, go out of their district, go farther, go to another -- you know, go to another municipality where there's another hospital that is less crowded.

So that needs support, and it needs to be engineered, and it needs to be carefully planned, and it need resources.

And it's very hard, when you've got a combination of volunteer services, paid services, municipal services, to get all these services -- you know, because it's so chaotic, as to how the services are structured, it is very hard to get them to interact and work so that we can do that load distribution.

Okay?

We have some things in place to do that, but we need a lot of support to do that.

And, again, I cannot emphasize the PPE aspect.

It's got to go, you know, kind of across the board, because these folks have no idea what they're getting into when they arrive in a patient's door, responding to a 911 call. And they are as vulnerable as -- like I said, they are as vulnerable to injury and disease and problems as police and fire.

And they've never been given that kind of status, they've never been given that kind of pay, they've never been given the kind of support that they need to have a real career, so that you have people who are not working three different EMS jobs just to stay alive.

ASSEMBLYMEMBER BYRNE: Thank you.

You know, I think one of our colleagues -- and I hope I'm not misstating this. Someone will correct me if I am. -- maybe Mr. Billy Jones has a legislative proposal to make it an essential service. It's something that's been discussed, I think, in the past.

And I completely agree with you as far as exposure and risks.

You know, the one benefit, possibly, when you're in the hospital, and someone is diagnosed with COVID, you know what you're dealing with. They have probably been isolated, and you have that information.

But if you're an emergency first responder going into a home, you have no idea. They could be calling for chest pain, and, all of a sudden, it's something very, very different, and you've already been exposed. And then you don't want to bring that back to your family and your loved ones.

So I appreciate your comments, sir, and thank you very much.

That's all.

SENATOR RIVERA: Thank you, Assemblymember.

And we have no one in the senate, but -- late hands, late hands.

ASSEMBLYMEMBER MCDONALD: There are more members in the Assembly than there is in the Senate.

So let's hear from our ranker, Brian Manktelow.

ASSEMBLYMEMBER MANKTELOW: Thank you.

This will be very quick.

Dr. Larsen, I want to -- I really appreciate your comments.

Being in a rural area, having a town ambulance that I was in charge of for nine years, county EMS, some of your things are so valid.

And even, you know, having an ambulance stationed at a fire department is hard in our rural areas because they're not always able to bill.

So I will be touching base with you again on this, making sure they are prepared for the next pandemic, the next issue that comes up.

I just really want to thank you, and everybody else that testified today, that you brought great things to the table.

It was good to hear from everybody.

And we, as legislators, now need to take that back and take action.

So thank you, all.

DR. ERIK LARSEN: I appreciate that.

Thank you.

SENATOR RIVERA: We don't have any questions in the Senate.

Assembly?

ASSEMBLYMEMBER MCDONALD: The Assembly rests.

SENATOR RIVERA: Are you sure?

I'm going to wait for 5 more seconds, because there might be one more assemblymember that throws their hands up late, as they usually do.

ASSEMBLYMEMBER MCDONALD: No, I don't think so. I think we're good to go.

SENATOR RIVERA: Yeah, so, with that, I will say to the panel, thank you so much for being with us this afternoon.

Enjoy the rest of your day.

That is the last panel, and the last of the three hearings that we have held.

And for anybody counting, we broke 31 hours: 10 hours in the first one, 13 hours in the second one, and 8 hours in this one.

So I will just repeat one thing, just procedurally, for everybody.

Remember, that if you have questions for any of the panelists, from the commissioner, on to the last ones that we just saw right now, that you believe have not been answered, please get us those.

In the Assembly, they go to my colleague in the Assembly, Dr. -- uh, Doctor -- Dick Gottfried.

And, if not, in the Senate, they come to me.

We will be putting those together, and we will making sure that they get sent out in an

official capacity, to, hopefully, be answered within a three-week period.

I want to thank, on the record, all of the staffers who, behind the scenes, made sure that this happened, from the Senate and the Assembly.

There are a lot of folks out there.

There's the person that manages the time clock. The person that manages, this; the audio, the thing, the other thing, the other thing.

Without these folks, we would not have been able to do it.

So thank you, all of you.

I will thank Stanley because he's the Senate dude, and I know him personally.

But there's a lot of other folks whose name I do not know, who are also -- and making sure that we actually made this happen.

So thank you for all of you.

And, lastly, I will just say, that this was a very -- even though it was 31 hours, it is eye-opening.

There are still questions that need to be answered.

It is -- as I said right at the beginning, this is both about accountability and establishing

better policy for the future, so that we can avert unnecessary debts.

I'm hoping that you all felt that we had that type of interaction with people so that we can have that information to do just that.

And I will pass it off to, the last word from my colleague in the Assembly, Dick Gottfried.

ASSEMBLYMEMBER GOTTFRIED: Yeah, well, first of all, I just want to echo what -- all the thanks and -- that Gustavo spread around to all the staff and witnesses.

Today's hearing was really exceptional.

I think we all learned a lot.

We all picked up a lot of questions we're going to have to pursue.

On the -- just one technical point, on the question of sending us follow-up questions.

And those of you on the Assembly side, you've gotten an e-mail from me on the point.

But, if you can put your questions into an attachment -- into a -- you know, a document you attach to an e-mail, preferably one attachment per witness who you want your questions to go to, I think that would make it a lot easier for us to send the questions out to the appropriate witnesses

and, hopefully, get answers.

And, thank you, all.

SENATOR RIVERA: All right.

And with that, I will say, thank you to all of you that hung out for this long.

And for those out in the public, because I know that there's like three people still watching, thank you so much.

Enjoy the rest of your week, and your day, and be safe out there.

Thank you, folks.

(Whereupon, the joint legislative virtual public hearing concluded, and adjourned.)

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