Commission on the Public's Health System

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Executive Summary
Sinking to the Bottom Line

This study and report were funded through an Individual Project Fellowship from the Open Society Institute. Judy Wessler and Linda Ostreicher received this funding to examine the impact of market forces on the public health and hospital system in New York City with an emphasis on access to health care services for low-income and immigrant populations. The examination included a quantitative and qualitative review of the public system and site visits to other cities to look for models that could be proposed for New York.

The qualitative review included:

- Literature search and review of 20 years of organizational and personal files;
- Freedom of Information requests filed with the Health and Hospitals Corporation (not all have been completed);
- Observational visits to seven HHC hospitals and two HHC Diagnostic and Treatment Centers;
- Interviews with twelve former and current high level administrators and board members of the Health and Hospitals Corporation;
- Group sessions with HHC employees at four hospitals;
- Attendance at four of the five HHC Annual Public Meetings in the Year 2000;
- Discussion of the initial recommendations at a Retreat held by the Commission on the Public's Health System;
- Four Town Hall meetings and two Focus Groups were organized with the

assistance of community organizations, a university, and a union; and

- Visits to four cities with public health and hospital systems to interview and observe.

The quantitative review included gathering and analysis of documents, including: historical reports; Health and Hospitals Corporation finance committee reports; data acquired from the Health and Hospitals Corporation under the Freedom of Information Act; and much more.

Introduction:

Public health advocates, and others concerned about the provision of health care for low-income communities, have a difficult time walking a tight rope between wanting to be supportive yet also needing to tell the truth. In this report you will read much in the way of criticism of the current functioning of the public health and hospitals system. Nevertheless, we believe that there is much good in New York City's public health system and that there is a tremendous need for this system, since almost 30%(1.8 million residents) of the city's non-elderly population has no health insurance, and the city-owned facilities of the Health and Hospitals Corporation (HHC) provides a tremendous, ever-growing percent of care to the uninsured. Last year, HHC provided services to 560,000 uninsured residents of the city. With shrinking public financial support from the city, in past years HHC reduced its budget by reducing the staff and consolidating services, while getting lump sum settlements from the federal and state governments. This year, HHC management projects a $313 million deficit in its budget on an accrual basis.

There are many other reasons why we support the public system which include:

- The mission and mandate to provide services to all regardless of the ability to pay;

- The provision of services because they are needed, not because they are reimbursed or get top dollar;

- The requirement to have a Community Advisory Board at each facility and to conduct business in the public domain with information publicly available;[1]

- The ability to respond to emerging epidemics, as the Health and Hospitals Corporation did in the last decade to HIV/AIDS and tuberculosis;

[1] The depth of this review would not have been possible in the private hospital sector since, although primarily publicly funded, it is not required to make public decisions or much of the information that is available in the public sector.

- The location in low-income areas and communities of color as the only geographically accessible facility in some neighborhoods;

- The attempt to adapt to immigrant populations and their needs, by providing culturally competent and linguistically appropriate services and care;

- The training of minority professionals; and

- The long-term policy of affirmative action that has employed people of color at all levels of operation of the system.

However, we also believe that the system is not acting like a system and is not functioning as well as it could, even under the difficult circumstances in which the HHC facilities find themselves. In a market place environment, in which there is serious competition for insured patients, including people covered with Medicaid, maintaining services and a balanced operating budget is difficult. Not having enough money is a serious issue. What you do to ensure that there is enough money is an issue. What you do with the money that you have is another issue. What do you do when there is not a level playing field and competition is stiff for "paying customers"? What do you do when funds for paying for the care of the uninsured are in short supply and the government is not talking about universal health insurance coverage? Public funding is often shifted away from safety-net providers to academic medical centers, which in New York are not providing their share of care for low-income communities.

Managed care, particularly for Medicaid beneficiaries, is fast becoming mandatory, and patients with this coverage have other options than the public system. There are 18 HMO's/PHSP's licensed in New York City to enroll Medicaid beneficiaries in managed care. The competition has become fierce, and enrollment sometimes fraudulent, to enroll the greatest number of Medicaid patients. The public system has much at stake in the competition for Medicaid patients, since Medicaid has been the life-blood of funding for HHC. Yet the public system, either through design or because of political forces or a combination of both, keeps shooting itself in the foot by concentrating on balancing its budget and making its facilities more physically attractive while allowing direct services to decline. This is the market place medical economy that has taken hold and in which we are immersed.

Some of the recommendations presented in this study will deal with the need to change the structure, governance and financing of HHC. These changes could significantly improve HHC's capacity to perform in a coherent and cohesive manner. The planning function is another key aspect that needs to be re-focused on meeting the needs of under-served communities and improving the services provided.

Although we are critical of the current management of HHC, we believe there are some excellent people within the organization who know what they are doing and why they are there. Ensuring that they are able to do what they need to do, is a major goal of

this project.

Sinking to the Bottom Line uses the concept developed by Baxter and Mechanic of the major elements needed to maintain a local safety net to evaluate the public health and hospital system in New York. The three major elements are:

(1) safety-net providers that are sufficiently competitive and innovative to maintain their traditional base of publicly insured patients;

(2) a reasonably stable mix of financing sources; and

(3) local markets that are not changing too rapidly for rational restructuring.[2]

Quantitative Findings:

The public health and hospital system has been hard hit by a combination of forces over the last decade. Those forces include the market place medical care environment in which we find ourselves. Competition is stiff for insured patients, but the playing field is anything but level for the 1.8 million people in the city who have no health insurance, the hundreds of thousands of other people who are under-insured with no coverage for many services (including the low-income elderly insured through Medicare), and the many others who may be insured but present with "undesirable" illnesses or social problems.

For the Health and Hospitals Corporation, as one person described it, the current mayor of the city can be termed another market force. A controlling, but unsupportive, city administration has been a disaster for the public system. Mayor Giuliani made campaign promises to privatize the public hospital system. Although he lost in the courts, in the media, and most especially in the communities, the Mayor has continued to push for other forms of privatization. His focus with the Health and Hospitals Corporation, besides failing to meet the state-legislated mandate to fund uncompensated care, has been mostly hostile and disruptive. There is an oppressive atmosphere in many of the HHC facilities, which was pronounced during interviews and group sessions.

The policy-making board of the HHC has been taken over with City Hall making many of the critical decisions. The board has also become less representative of the patients served in the HHC system and of the employees who staff the HHC facilities. The 2000 Census points to a "minority/majority" population in New York City with the number of white residents shrinking to well under 50%. The population of the city has swelled to over eight million residents, with immigration from other countries playing a

[2] Baxter, Raymond J. and Robert E. Mechanic. "The Safety Net vs. the Market: Is the Safety Net In Crisis?" *Health Affairs.* Vol. 16, No. 4 July/August 1997. Page 18.

large role in this increase. Nearly 50% of new babies born in this city have immigrant mothers.

The combination of market forces and an unsupportive administration has taken its toll on the services needed in this city. ***Sinking to the Bottom Line*** found massive changes in the public health system over the last decade.

From 1994 to 1999:

_The number of people in HHC beds on an average day went down by 39%.
_The number of times patients were admitted to HHC hospitals to stay at least overnight went down by 11%.
_The number of days the average patient stayed in an HHC hospital bed went down from 8.2 days to 5.3 days.
_The number of general care hospital beds was cut in half.
_The staff of HHC was reduced by one out of four employees.
_The number of uninsured patients served in HHC facilities increased.

The Mayor and HHC management assert that because there are fewer patients in HHC beds, HHC isn't needed as much, and doesn't need money from the City. This report looked at why HHC beds are not being used as much, and found there were other reasons too:

_ More people with Medicaid are using private hospitals.
_ HIV/AIDS and TB patients can now often be treated without people having to be hospitalized.
_ The city stopped giving HHC payment for services provided, so the hospitals and other facilities had to find ways to save money.

The HHC has been trying to save money by:

_ Sending people home from a hospital bed earlier;
_ Reducing the number of employees by 1 in 4 workers;
_ "Consolidating" services, which means some patients have to go to more than one place to get all the different services they need, even if it is difficult to travel, such as for rehabilitation services;
_ Cutting back or not expanding services to the amount that people need, for example:
_ Children's psychiatric beds have been more than 100% full for the last two years.
_ There is a great shortage of certain kinds of care that often isn't covered even for those who have insurance, such as dental care, mental health care, and substance abuse treatment.
_ HHC serves some of the communities where pregnant women are least likely to get the medical care they need, and yet it's losing maternity

patients. The need is there, but HHC is not reaching the patients.

Sinking to the Bottom Line found that HHC services are needed as much as ever, but now it is primarily the outpatient (clinic) services that need to be expanded. However, HHC is planning to reduce its outpatient services and has placed a moratorium on construction for new clinic services. The Renaissance Health Care Network in Central and West Harlem is the saddest current example of this problem. This phenomenon is happening because:

- HHC loses money on every clinic visit, so they don't want more visits.
- However, because some of their costs are overhead, like rent, and are the same no matter how many visits they get, if they expand intelligently, the more visits they get, the less money they lose.

One group of people that is using HHC services more than ever is people without insurance, or without enough insurance to cover the care they need.

- 1.8 million New Yorkers have no health insurance.
- Most people without insurance work full-time, or their dependents, but do not get benefits from their jobs.
- The number of people without insurance keeps growing, as more people lose Medicaid or get new jobs without health insurance.
- Last year, HHC treated 560,000 people who had no insurance.
- Private hospitals are only required to provide services to the uninsured in an emergency, and are admitting fewer patients without insurance, while HHC is admitting more such patients.

HHC, in response to these market forces, is trying harder to collect payments from people who have no insurance, by:

- Asking more patients for the information needed to see if they are eligible for Medicaid or Child Health Plus;
- Increasing the administrative fee for medications and asking patients for these fees before they can get prescriptions filled;
- Asking patients for fees before they can see a clinic doctor; and
- Turning more of the patients' bills over to collection agencies.

These actions discourage people from coming to hospitals and clinics:

- Many people, especially immigrants, worry about all the questions they have to answer to apply for Medicaid. Because of recent federal and state laws, new immigrants are not eligible for Medicaid.
- Patients aren't always clearly told that if they can't pay a fee ahead of time, they can still see a doctor and get medicine.
- Once a patient is being threatened by a collection agency, they are afraid to return for care, even if they are seriously ill.

HHC is thinking smaller these days, and not looking ahead:

- Yes, fewer people today need its hospital beds. But, in 10 years, the first Baby Boomers will be old enough to get Medicare. This aging population is bound to need more hospital beds.
- HHC has taken on the responsibility for real estate and is involved in planning for the selling-off of some hospital property and buildings. HHC should hang on to its buildings and land, temporarily using them for other health-related purposes, until it needs to expand its beds again. Even so, Queens Hospital Center will soon open its' new hospital building with 60 fewer beds than its' current complement. Some patients will be forced to travel to other boroughs for services, unless HHC and the city change their current plans to sell-off the "excess" buildings.
- A good example of long-term thinking is what Kings County Hospital is doing: building an "assisted living facility" for senior citizens who need a little help, but don't want to go to a nursing home.
- Many other essential services could be placed in unused hospital space (such as Harlem Hospital's buildings), run by community-based providers, such as:
- Day programs for the elderly and the developmentally disabled; and
- Residential facilities for the mentally ill and substance users.
- Extra space could also be used to provide beds for family members who want to stay overnight with hospitalized patients.

Qualitative Findings

The Regional Networks set up by HHC, ostensibly designed to improve service delivery and move decision-making closer to the community, have accomplished neither major goal. Instead, for the most part, local fiefdoms have developed around the new Senior Vice Presidents of the regional networks. Each head of a network is also the director of at least one of the facilities in the network, and "their" hospitals have benefitted from this association. Strategic planning efforts have turned from community needs assessments and planning for the delivery of community-based care to how to modernize facilities and rationalize services. Planning is financially driven, with little relevance to community needs. Community-based ambulatory care services, the basis for managed care, have been ravaged to cut costs and feed the need of the hospitals. Long term care services, for the most part, have been ignored.

HHC had the opportunity, within the Community Health Partnership funded through the federal dollars of the Community Health Care Conversion Demonstration Project (see special section of the report describing CHCCDP), to fully develop their primary care services and their work force, and to develop partnerships with community-based safety-net providers. This golden opportunity has almost been lost in the first cycle of the funding.

Talking with current and former employees of the HHC, observing in HHC facilities, listening to testimony and discussion at public meetings, holding Town Hall meetings and Focus Groups, and reviewing documents revealed:

- HHC acts as a part of city government, even though it has quasi independent status.
- Decentralization of power to the networks is an illusion because the role of network managers is to execute the policy of the city.
- The HHC regional networks have internal competition and compete among each other, while having to compete with private health care providers.
- The transfer of the Emergency Medical Service from the Health and Hospitals Corporation to the Fire Department in 1996, was a serious mistake.
- There is a changed atmosphere in HHC facilities due to market forces and city interference in operations. One employee described the change internally as: "Do what you do for gain, we now have customers." Management and employee relations are hindered by, as one person described it: "the need to make the Mayor look good at whatever cost." This focus has resulted in, what has been described, as a repressive atmosphere.
- Forced overtime and serious shortages of critical staff have placed a great deal of stress on employees. At one Town Hall meeting, a union representative for HHC chemists and lab technicians raised key issues about staffing and patient care. He said: "Repair technicians are forced to decide...should I take care of the heart or the lung machine?" Nursing is another area of staffing concern. A nursing representative described the problem as "the hospital only looks at the number of patients, but they must also look at the patient acuity, the complexity of the illness." Nurse staffing at one hospital in one inpatient unit was described as: "three RN's with twenty patients, two of whom were on ventilators to help them breathe and required additional nurse staff time."
- Several HHC employees noted an increase in negative interactions between patients and staff. They expressed concern about the belligerent attitudes of more patients. This attitude was attributed to the long waiting times and the frustration felt by many patients. At the same time that more security is needed, the HHC is proposing to privatize and downgrade the security staff.

Unannounced observation site visits to nine HHC facilities focusing on the primary care clinics and the pharmacy showed difficulties and obstacles from beginning to end of the consumer's journey in accessing health services. Long waiting times, problematic staff behavior, burdensome administrative fees, lack of information, and limited language access were identified as significant barriers to services. For example:

- **Lincoln Hospital:** The number of people in the waiting area for the Orthopedic clinic doubled to almost 40 within an hour. Many patients were

standing throughout the waiting area and adjacent hallway because there was not enough seating available.

- **Kings County:** A visit to Kings County Hospital's Adult Walk-In clinic showed approximately 60 people were seated in the waiting area. An additional 15 people were seen standing throughout the waiting area because all available seats had been taken.

- The waiting areas of child health clinics at **Harlem Hospital, Lincoln Hospital and Morrisania D&TC**, were filled to capacity with a shortage of seating, leaving parents and children standing in the waiting areas for extended periods of time.

- **Bellevue Hospital:** A young man did not have the $6 administrative fee for his medication. He was told "bring the prescription back when you have the money." The man left the pharmacy area without the medication.

- **Elmhurst Hospital:** The observer asked the cashier in the pharmacy area whether a patient could receive medication if they were unable to pay the required administrative fee. The cashier indicated that it would not be possible to obtain medication unless the patient paid the posted fee. The cashier then also recommended that the observer go to a Financial Counselor or Patient Advocate to "work something out."

- At several hospitals, employees volunteered that they had given out-of-pocket money to some of their patients so that they would not have to leave without their medicine.

- A nurse at the Harlem forum told of one of her TB patients having no access to his needed medication for three weeks.

- **Bellevue Hospital:** Over 15 people were seen standing in line for over two hours to see a Financial Counselor. There appeared to be only one person working in this office.

- **Elmhurst Hospital:** During one visit, over 25 people were observed waiting to meet with a Financial Counselor.

- **At all facilities:** There was no posted information about the pharmacy fees, nor was there any information available about waivers of the fee.

Lessons from other Cities:

Two of the cities — Cambridge/Somerville in Massachusetts and Denver, Colorado — have model public health and hospital systems. The Los Angeles public system has many good programs and facilities, but has some similar problems to those

found in New York. Some observers attribute many of these problems in Los Angeles to the systems location in county government. The Public Benefit Corporation in Washington, D.C., is particularly troubled. The city government is in the process currently of attempting to shut down the one public hospital in the nation's capitol. Three of the cities compare very favorably to the public system in New York.

The elements of success in the three cities are described and portrayed in a chart in this study: Public Health System/City Characteristics. The elements of success are:

- Strong, stable, visionary leadership;
- Accountability;
- Public funding for the uninsured from various levels of government;
- Integrated system with an emphasis on community-based primary care;
- Planning efforts, with an understanding of the population served and the communities in need;
- Language and cultural competence in the provision of health services;
- Preparation to be competitive;
- Strong HMO and/or Primary Care Case Management program;
- Ability to attract other funding;
- Support from elected officials;
- Support from the community; and
- Support from labor.

The experience of these cities proves that a public system does not have to provide poor and underfunded services because it is the major provider for low-income people, immigrants, and communities of color. On the contrary, there is enlightened leadership in other parts of the country that has provided models of what can be done when there is a commitment to the public health sector. Access to care, and the quality and quantity of the services, all benefit from this attention. The visitor heard community advocacy organizations say that access to care is not a problem in Cambridge or Denver. Financing for this care from state and local governments made a world of difference. This is unfortunately, not the case in New York City where observations and testimony from consumers tells a different story.

In the immigrant focus group, when participants were asked what they do when they get sick, several talked about non-traditional medicine, self-care, and delays in seeking medical attention. They overwhelmingly said they could not afford insurance coverage nor the cost of visiting a clinic. When they did mention going for emergency care when they got sick enough, they almost unanimously mentioned a public hospital. Many of the immigrants did not know which facility was a public hospital. They were also, often unaware of the mission of the public system to serve everyone regardless of the ability to pay. Nor were they aware of the sliding fee scales based on income and family size in the public system.

Town Hall meetings/Focus Groups:

The outcomes of the four Town Hall meetings and two Focus Groups are described in this report. There were common themes in most, if not all of the Town Hall meetings/Focus Groups:

- The public system plays a key role in providing services in low-income and immigrant communities;
- There is a need to change the board of the Health and Hospitals Corporation to be more reflective of the patients and staff;
- There is a need to minimize the Mayor's influence on the budget and decision-making in the HHC;
- There is a need to address the primacy and politics of the private health sector;
- There are patient care problems;
- There is not enough staff;
- There are access to care problems expressed as the HHC moving away from its mission;
- Communities need to be more active in the public hospital system;
- Language barriers are not always being addressed;
- HHC Community Advisory Boards need technical assistance and educational sessions and more patient representatives on the boards;
- There is a need for outreach and selling the ideas and preliminary recommendations from ***Sinking to the Bottom Line***;
- There is a great need for coalition efforts between labor and community;
- Elected officials need to be more accountable for what they are doing to help the public health and hospital system; and
- Labor unions need to think about not supporting incumbents who are doing nothing to help.

Recommendations:

All of the work involved in preparing this report, led to a series of recommendations for needed change in the Health and Hospital Corporation. The recommendations were distributed at each of the forums organized around this report. Additional recommendations were incorporated based on what we heard from people attending these sessions.

Also, a summary of the goals and work of the study was prepared and distributed in English, Spanish and Haitian/Creole. The summary contained some of the findings and some of the recommendations for ***Sinking to the Bottom Line.*** Feed-back was obtained from many people based on the contents of the summary and presentations to groups and organizations.

RECOMMENDATIONS

Sinking to the Bottom Line

I. For the Health and Hospitals Corporation:

A. Services and Access to Care

1. The foundation of HHC's continuum of care should be primary care, and therefore clinics must receive a higher share of resources and staff. This is especially true for clinics which are not in hospitals, such as D&TCs, child health centers, Communi-care sites, and other freestanding clinics.

2. Each facility should offer the secondary services needed by its community. For example, orthopedic services, which were shifted from Queens to Elmhurst Hospital, should be returned to Queens Hospital. Pediatric inpatient services shifted from North Central Bronx (NCB) to Jacobi Hospital should be returned to NCB.

3. Most consolidation of services should be limited to tertiary care, and should be based on research and analysis of HHC's patients' needs and the system's resources in each borough. Objective analysis should determine whether public facilities are acting as a system or are "rewarding" affiliates and other private providers with specialty care referrals. Whenever possible, HHC should refer its patients to resources within its own system, e.g. heart surgery patients should be referred to Bellevue.

4. Every affiliation contract with a medical school or teaching hospital should be reviewed to determine if the agreement is still warranted and needed. The review should include the affiliate's performance in meeting Affirmative Action standards in residency training and hiring of all professional staff. It should also include the commitment of the affiliate to the primary mission of the Health and Hospitals Corporation, and the support given to accomplish this mission.

5. HHC should require its collection agencies to limit their activity to collections from third party payers, such as Medicaid and private insurance.

6. Co-payments for services and prescriptions should be replaced by increased efforts to collect third party payments.

7. Mental health and substance abuse/alcohol outpatient and inpatient services need expansion, especially for the uninsured and for special populations which are underserved, such as immigrants, the elderly, pregnant women, and adolescents.

8. Primary and specialized dental services to children and adults must be restored and expanded. There is a large unmet need for dental services in low-income populations.

9. HHC should guarantee that health services are offered in a safe and linguistically competent way. Services must be available to people in the primary languages they speak through health care providers and trained interpreters whose specific job is to interpret for patients.

10. HHC should continue to expand the range and quantity of preventive services, considering such options as:
    - Offering free chest X-rays and breathing capacity tests, to screen for lung ailments. When problems are diagnosed in smokers, they are more open than usual to invitations to quit smoking and make use of cessation services, which should be expanded.
    - Developing culturally competent health education materials in multiple languages, offering a broad range of ways to stay healthy.
    - Opening health clubs to serve outpatients and provide physical therapy. Compared to commercial clubs, hospital-run clubs enroll older members and are more oriented toward health rather than athletic achievement.

11. HHC should maintain its maternity market share by:
    - Expanding services to women not receiving prenatal care elsewhere. Many women, especially those who practice Islam, are not comfortable with male employees in an OB/GYN department. OB/GYN units entirely staffed by women would appeal to these women, and could use female midwives, nurse-practitioners, and doulas to supplement the inadequate supply of female OB/GYN specialists.
    - Offering support services during the perinatal period, such as pre- and postnatal classes open to the whole community, not just the facility's own patients; lactation support groups; postpartum depression sessions; and classes for young siblings who need to adjust to a new baby.[3]

12. HHC should target patients beyond mothers and children by increasing outreach and services to the elderly, the near-elderly, and adult men and women without children. Examples include:
    - Increasing HIV/AIDS counseling and testing for men.
    - Increasing resources for screening, diagnosis, and treatment of chronic diseases, such as asthma, diabetes, and hypertension.

13. HHC should identify and expand profitable services which are also needed by the community, such as orthopedic surgery; radiology; ambulatory surgery, and neonatal intensive care.

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[3] *Hospitals hope births create life-long clients.* Charlotte Business Journal, by Shannon Reichley. November 11, 1997.

B. Planning

1. HHC should choose the amount and kind of services it provides based on the needs of the patients it already treats. Patients will receive better care, and are more likely to stay with HHC, if the Corporation expands the range of needs it can meet for each patient.

2. HHC should identify communities and services which need additional resources, and obtain new funding or shift resources to meet those needs.

3. HHC should be working with other community-based safety net providers in coordinating planning, funding, and sharing of services. These linkages would make both the HHC and the other safety net providers more financially and medically viable. An example of this type of coordination can be found in HHC's grant from the federal government for the Community Assistance Program (CAP), in which HHC has contracts with ten community-based providers to coordinate outreach, care, and services.

4. HHC should actively seek funding in advance for the care it delivers to the under and uninsured — although not from the patients themselves - making an annual public report on the amount and cost of care it currently delivers before the Mayor releases his preliminary city budget.
5. The Council of Municipal Hospitals Community Advisory Boards (CABs), on behalf of its member CABs, should start a formal planning process to develop a short-term and a long-term strategy for meeting the needs of the communities each CAB represents.

6. HHC's affiliated medical schools and academic medical centers are paid to provide doctors and other professionals to HHC hospitals. The Corporation needs to make sure that its service mix is decided by what is best for patients, not by what is best for the affiliates' need to teach medical students and conduct research.

7. Individual HHC facilities have shown considerable ingenuity in creating and locating models of innovative care that also helps its financial position. HHC should expand successful models to all suitable facilities.

8. HHC should link up with unions, community organizations, and other safety net providers to make sure that the formula for the final two years of the five-year Community Health Care Conversion Demonstration Project (CHCCDP) funding is distributed more fairly, restoring the current reductions in the share going to safety net hospitals that are planned for the second and third years of this five year program.

9. Staff training is planning in action, as it affects the future capacity of HHC's workforce. The CHCCDP funding earmarked for staff training should emphasize:
   a. Upgrading basic skills, such as GED training and community college

courses;

b. Providing upgrading training for different levels of staff, such as upgrading of Nurses Aides and Licensed Practical Nurses;

c. Increasing the number of staff at all levels who can talk about health care with patients whose primary language is not English. This includes the wide range of languages in immigrant communities and American Sign Language. Each facility should target those languages most common among the community it serves.

d. Training staff in cultural competence beyond language skills, addressing such issues as different communities' attitude toward volunteering medical information, gender issues between patient and staff, following medical advice, and seeking and receiving mental health treatment. Cultural competence training should also teach staff about the basic living conditions of their patients, such as what kind of meals are normally eaten, the quality of housing, and the ability of the patient to get help from neighbors and family.

10. HHC should find innovative uses of former inpatient space that complement medical services, such as:

- Renting or giving space to health-related services delivered by community based organizations, such as day programs for the elderly and the developmentally disabled, and residential facilities for the mentally ill and substance abusers. Sites for many essential services are difficult to find because of NIMBY opposition. Locating them in an HHC facility would eliminate the problem of bringing new traffic congestion or unfamiliar populations into a neighborhood. HHC should then negotiate contracts to provide services for these populations.
- Adapting extra inpatient space to provide beds for family members wishing to stay overnight with patients. This would be an appropriate use for double rooms that many patients no longer wish to share. By making relatives welcome and comfortable during a patient's stay, the professional care provided by hospital staff is supplemented by the personal care provided by family members.

11. HHC should start planning now for the needs of the aging population of the city. These include:

- Maintaining adequate staff and bed complements in its existing long-term care facilities.
- Monitoring on a yearly basis whether the need has grown for long-term care beds, rehabilitation beds, other alternative level of care beds, rehabilitation services, and home health services.

C. Structure and Governance:

1. Change the HHC structure to eliminate dominance by the city's Mayor. Legislative language exists which would broaden the responsibility for appointing the Board of

Directors, while reducing the Board complement to 11 members. Three members would be appointed by elected state officials, three by the mayor, three by the City Council, and one by the Council of Municipal Hospital Community Advisory Boards. The 11th member would be the Chair, and be chosen by the other members.

2. Locate real decision-making on governance and other non-medical policy in the Board of Directors, whose members would be qualified for the position by knowledge of either a health-related specialty or the needs of a community served by the Corporation.

3. Further decentralize the system by allowing more decision-making at the facility level. Retain the basic network structure, redrawing boundaries along borough lines, unless there is an overwhelming need for different boundaries in specific cases. Appoint different individuals as Executive Directors of each facility, and appoint still other individuals as Senior Vice Presidents of the Networks. Base the Senior Vice President's office in the facility that most needs support and attention, not the largest and strongest one.
4. Provide and publicize ways that staff and patients can have two-way communication with the administration. Eliminate practices that lead to staff fears of speaking out.

5. Produce and distribute adequate numbers of reports on the state of the HHC system, containing substantive information, including statistics about individual facilities, networks, and the corporation as a whole.

II. <u>For the City of New York</u>:

1. The City of New York should meet its financial obligations to HHC and its patients by:

   - Restoring the payment of a subsidy for any care for which HHC receives no other compensation;
   - Paying for debt service on HHC capital projects, because the buildings belong to the city;
   - Paying for maintenance of HHC buildings which are converted to other uses temporarily, until the probable increase in inpatient usage arrives;
   - Reimbursing HHC for the $77 million it had to pay when construction on Kings County and Queens Hospital was abruptly halted by Mayor Giuliani upon entering office;
   - Reimburse HHC for past payments to HRA for Medicaid eligibility staff stationed in HHC facilities, and pay their salaries in the future. Determination of Medicaid eligibility is the City's responsibility, not HHC's.

2. Funding for HHC and other public health services could come from the $250

million in tobacco settlement money that the City expects to receive annually. At present much of this money is being spent on school construction, which is a capital cost more appropriately funded from long-term bonds.

3. Now that the city Department of Health (DOH) has greatly reduced its capacity to provide direct services, it should work through HHC to respond to the needs identified by its epidemiologists. DOH should take the lead in identifying emerging or re-emerging illnesses, whether they are contagious, like Hepatitis C, or non-communicable, like the ever-growing asthma and diabetes problems. DOH should also enforce the contracts with HHC for services provided by HHC under state Article 6 Public Health Funding, such as for the Child Health Centers.

4. The placement of the EMS system in the Fire Department is not working. The FDNY acts as a Uniformed Services unit, whereas the mission of the EMS is medical; the cultures are not working together. Under FDNY management, more areas of the city are served partly or completely by private ambulance services, including for-profit companies. These services are staffed by teams that are not as highly trained as EMS staff. The Fire Department gives city equipment and supplies to these services, including those which are for-profit companies. The city should either return EMS to HHC or make it an independent agency.

III. Strategic Plan for New York City Community Organizations, Consumers, Health Professionals, and Labor Unions:

1. Conduct outreach to present the findings in this report and our recommendations to Community Boards, community and religious organizations, labor, and other groups in communities throughout the city.

2. Form a coalition around the recommendations in this report, prioritizing them so that initial victories can build momentum for larger successes. Two areas that are natural priorities are changing the governance of HHC and introducing adequate funding mechanisms to cover its deficits. The coalition will need to include patients, labor unions, individuals health care workers, religious and community organizations, elected officials, and medical professionals.

3. Join the Commission on the Public's Health System and the New York AIDS Coalition in building a network of Public Health and HIV/AIDS organizational support around a public health policy and budget agenda, including specific recommendations for HHC. Both community organizations and individual activists are needed for this work.

4. Organize to increase public funding for HHC from federal, state, and local government, to continue providing care for everyone regardless of their ability to pay. For example, challenge the cap on state allocation of Bad Debt/Charity Care and DSH funding for the public health and hospital system. Ensure that the city is living up to its state-mandated legal responsibility to provide city funding for HHC

services for which there is no other source of revenues.

5. Build community, labor, and political support for state legislation changing the HHC enabling law, freeing the Corporation from city control while maintaining its mission, principles, and public accountability.

6. Assist the Community Advisory Boards (CABs) in developing their capacity to actively represent their communities, by providing training, technical assistance, and other support. Help orient new members to HHC history and issues. Encourage cooperative activities among individual CABs and between CABs and other community organizations. CAB members need to be reminded about the role they play in representing the interests of the community, not the needs of the administration of the facilities.

7. Communities need to identify additional services, or increases in current services, that are needed. For example, the pediatric inpatient unit at North Central Bronx Hospital must be reopened; the mental health and substance abuse inpatient and outpatient services at Queens Hospital must be maintained; the ambulatory care network of the Renaissance D&TC must be restored and expanded.