COMMUNITY BOARD NO. 2, MANHATTAN

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HUMAN SERVICES

The Human Services Committee of Community Board No. 2, Manhattan, held its regular monthly meeting on June 26, 2025, at 6:30pm in hybrid format.

Committee Members Present: Susanna Aaron (Chair), Zachary Kazzaz, Janet Liff, Emma Smith
Committee Members Absent With Notice: Arturo Fernandez, Juliet Kaye, Ryder Kessler
Committee Members Absent: Keen Berger, Ritu Chattree (Vice Chair)
Public Members Present: Rachel Yarmolinsky
Other CB2 Members Present: Donna Raftery

Attendance did not achieve quorum

Agenda
Guests:
-Andy Cook, Director, Street Health Outreach & Wellness (SHOW) Program, NYC Health + Hospitals
-Erfan Karim, Chief Clinical Operations Officer, NYC Health + Hospitals

REPORT: SHOW Vans

-SHOW stands for Street Health Outreach and Wellness, run by H+H as a form of street medicine.
-It provides primary care, wound care, behavioral health, addiction services, and social work to people experiencing unsheltered homelessness.
-The program delivers services via mobile vans (actually, small buses) that function as clinics and outreach hubs.

Operations and Infrastructure
-Number of Vans: 5 currently active, a 6th is launching soon.
-Each van is tied to a specific H+H hospital with a "safety net" primary care clinic (e.g., Bellevue, Elmhurst, Lincoln, Woodhull).
-Bellevue currently operates 2 vans: one at Sara D. Roosevelt Park and one in East Harlem.

Staffing and Service Delivery

-Staff per van (when fully staffed): ~7 members including medical provider, nurse, social worker, addiction counselor, community health worker, clerk/admin.
-Hours: Monday–Friday, 9am to 5pm.
-Vans are stationary so patients without phones/internet can rely on consistency.
-Staff split their time between working at the van and "roving," i.e., walking or taking public transit to engage individuals nearby.
-SHOW staff remain in contact with other city agencies, such as Department of Homeless Services.

Access to Care
-No ID or insurance required.
-Services are open to anyone, though primarily serve street-homeless individuals.
-Over-the-counter meds are available; prescriptions can be written.
-Common services include wound care, chronic disease management (diabetes, hypertension), and psychiatric care.

Funding and Cost
-Annual cost per van: ~$1.5 million (includes vehicle, staff, supplies, logistics).
-City-funded for 6 total vans. Program cannot currently expand beyond that.

Outcomes and Metrics
-Over 2 years, the program overall has conducted the following:
    -30,000+ "engagements" (distributing supplies, wound care, talking to clients)
    -3,000+ documented medical or behavioral health "encounters" (entered into medical records)
-SHOW-engaged street homeless patients are more than twice as likely to maintain primary care: 24% of SHOW patients have sought further primary care in the H+H system, whereas only 9% of street homeless patients who've visited an ER, and who are NOT engaged with SHOW, are individuals who have sought further primary care.
-The estimated street homeless population in New York city is 4,000-5,000. SHOW vans have about 1,100 active patients at any time.

Program Goals
-Encourage patients to eventually engage with the broader H+H system (e.g., safety-net clinics).
-Reduce ER visits by increasing regular primary care visits.
-Build trust over time, often with patients who have had negative healthcare experiences.
-Create a pathway to housing when possible, though these cases are still limited.

Committee Questions and Concerns
-Scalability: Funding constraints prevent the program from being expanded.
-Staffing challenges: Recruiting and retaining the right personnel for this difficult work remains a challenge.
-Neighborhood concerns: Committee asked whether a SHOW van in their district would create visible street congregation or lines. Cook responded that they're usually embedded in areas where the population already is and have not been disruptive.

-Referrals & System Navigation: SHOW social workers offer "warm handoffs" to city services (HRA, other outreach teams, housing).
-Psych Crisis Protocol: For psychiatric emergencies, SHOW teams activate EMS by calling 911.
-Relationship with known individuals: Teams build relationships with repeat patients and maintain continuity through H+H's medical record system.

REPORT: Bellevue Hospital

Beth Israel's closure has raised alarms about regional capacity for both emergency and psychiatric care.
Bellevue is now the only Level 1 trauma center south of 68th Street, and the largest psychiatric care provider in Manhattan.

Bellevue Overview

Oldest public hospital in the U.S. (289 years), now operating:
-900+ total beds
-~200 psychiatric beds
-100 forensic psychiatric beds
-~60 child & adolescent psychiatric beds
-Bellevue provides ~50% of psychiatric care within the H+H system.
-70% of Bellevue revenue comes from Medicaid.
-Its building was designed in 1958 and opened in 1973.
-More information about Bellevue and H+H, including Community Needs Assessments and Implementation Plans, can be accessed here.

Emergency Department Capacity

-ED volume has grown from 400–450 patients daily (pre-COVID) to 850–900 today. They have not turned away any patients but acknowledge increased strain.
-Ambulance diversions occasionally occur when psychiatric ED (CPEP) is full.
-Bellevue recently implemented "lean" efficiency processes to reduce bottlenecks, improve flow, and manage inpatient boarding. Result: Reduced number of ER "boarders" (admitted patients waiting for beds) from ~60 to near 0 on some days.
-The ED is the entry point for the vast majority of patients who become admitted to the hospital and go "upstairs."
-When the ED is at full capacity it can request that ambulances "divert" patients to other facilities. This has happened on occasion. Shy of that limit, increased volume can mean longer wait times, especially for patients with less acute needs.

Impact of Beth Israel Closure

-Mount Sinai Beth Israel Hospital (MSBI) closed its doors on April 9, 2025.
-With the closure of Beth Israel and its CPEP – Comprehensive Psychiatric Emergency Program – Bellevue remains the sole CPEP in lower Manhattan.
-Bellevue has absorbed additional psychiatric and emergency volume.
-Patients previously seen at Beth Israel now show up at Bellevue, sometimes sicker and requiring admission.

-Mount Sinai has coordinated to allow Bellevue to transfer inpatient psych patients to its new behavioral health facility, Rivington House, when appropriate, although Rivington House does not accept psychiatric emergencies from the CPEP.
-Bellevue is also participating in an urgent care expansion initiative, as Mount Sinai attempts to offload some ER burden through 24/7 Medicaid-accepting urgent care (timeline unclear).

Psychiatric and Housing Services

-Bridge to Home: Launching soon. Transitional housing for psych patients not ready for full discharge.
-Respite Care: For patients without homes but not needing hospital-level care.
-Bellevue sees patients who stay in hospital 5–7 years because they lack safe discharge options.
-H+H is also building permanent housing at other sites (e.g., Woodhull in Brooklyn).

Funding and Budget Needs

-Bellevue's annual budget is $1.6 billion. (For finances of the full H+H system, see here.)
-The hospital's aging infrastructure requires continued investment. Some current equipment is 14–20 years old, well beyond the standard 7–10-year life cycle.

Bellevue's top capital improvement needs today include the following:

-Two new CT scanners
-Stroke imaging equipment ("single plane room")
-New PICU (Pediatric ICU)
-Total capital need: \~\$23 million for these three upgrades alone.

RESOLUTION IN SUPPORT OF ADDITIONAL INVESTMENTS IN H+H BELLEVUE HOSPITAL

WHEREAS

1) Bellevue is the Level 1 trauma center nearest to residents of CB2; and
2) Bellevue has experienced an increase in volume in its Emergency Department following the COVID pandemic and the closure of Mount Sinai Beth Israel Hospital (MSBI) on April 9, 2025; and
3) The closure of MSBI has left Bellevue as the only remaining CPEP – Comprehensive Psychiatric Emergency Program – in lower Manhattan, and it is often at capacity; and
4) Given the high incidence in Community District 2 of individuals suffering serious mental illness, the loss of a facility that can accept psychiatric emergencies is disconcerting; and
5) While Northwell Greenwich Village Hospital has expanded its services within CD2, its emergency department still has gaps that require CB2 residents to rely on Bellevue; and
6) The $20 million in funding and the capital equipment that MSBI has promised to invest in Bellevue to improve services seems inadequate compensate for the added volume from the MSBI closure; and
7) The loss of MSBI's Emergency Department in lower Manhattan is likely to continue to increase volume at Bellevue, which may decrease patients' timely access to care even if the most serious emergencies are adequately addressed.

THEREFORE, BE IT RESOLVED THAT COMMUNITY BOARD 2, MANHATTAN

1) Calls upon the New York State Department of Health to gather and share detailed metrics on the performance of Bellevue in delivering high quality service at every level of care, including diversion rates, time of "boarders" remaining in the ED before transfer to a bed, cycle time for patients, and time required for cases that are not immediately life-threatening but that can only be addressed by a trauma center such as Bellevue; and
2) Presses NYS DOH to negotiate for greater investment in Bellevue by Mount Sinai Beth Israel as compensation for the void that its closure leaves, not only in its immediate district but throughout lower Manhattan; and
3) Supports Bellevue's current requests for increased capital funding, especially for an additional CT scanner and a single plane (or bi-plane) angiogram for treating victims of stroke.