RESPONSES TO THE DCAB QUESTIONS RAISED ON February 28, 2025
FROM THE SUNY DOWNSTATE COLLEGE OF MEDICINE (COM) CHAIRS
UNDER EXECUTIVE LAW SECTION 996
APRIL 28, 2025

In response to questions raised on February 28, 2025, during the DCAB meeting with the Chairs of the College of Medicine and following new information that includes the March 21, 2025, *Crain's* article titled "Floated SUNY Downstate proposal would shrink, but not shutter, hospital services," the Chairs are responding in writing to each question to reinforce our position on the modernization and revitalization of University Hospital at Downstate (UHD). As UHD's clinical and academic leaders, we are committed to the institution and its success. Our community and our learners need UHD as an autonomous, independent, academic teaching tertiary care hospital physically connected to the Colleges. This is essential to best support our learners and to continue to attract academic physicians whose mission is to serve our community and educate and train the next generation of physicians and other healthcare professionals, who in turn stay to serve this community.

We wish to reassert our unanimous opinion that moving UHD to another facility as either an interim step or a long-term solution would irrevocably fracture the clinical enterprise in a way that would make the task of rebuilding daunting and greatly harm the health of our community as a result. We believe it is critical to preserve the cohesiveness of the clinical infrastructure alongside creating more efficiencies in preparation for a move to a new or revitalized facility. We stand by our proposal submitted on February 28, 2025, and have restated part of our justification below, followed by our written responses to the questions posed.

**Justification for a modernized full-service academic medical center in Brooklyn**
We remain committed to providing high-quality complex services to our community close to their homes. We believe that our community deserves a modernized full-service tertiary care academic medical center dedicated to addressing healthcare disparities through research, training of future generations of physicians, and advocacy through clinical care. How this edifice will be constructed in a cost-effective manner, we leave to the expertise of contractors and development managers. As clinical and public health experts with decades of experience working in this community, we continue to advocate for the needs of our patients. We reiterate that this new and/or modernized facility needs to allow for advanced healthcare services in a patient-friendly environment that reflects the quality of care we are committed to providing.

While the new edifice is being constructed, we would like all clinical services to remain in the current building. This would allow for 1) uninterrupted services during the period of construction of the new building, 2) the rebuilding of clinical programs and service lines based on our community needs, and 3) improved operational efficiencies, including establishing a new EMR, in preparation for moving into the new facility. We again reiterate that displacing the UHD clinical services into another hospital facility will be detrimental to the short- and long-term care we provide.

UHD's mission is too complex and extensive to become absorbed into a community hospital that does not prioritize the education of the next generation of physicians, nurses, and other health professionals as part of its mission, vision, and values. The academic mission and interconnectedness with the College of Medicine (COM) make UHD a magnet for some of the most talented academic physicians in the borough and NYC as a whole. Physicians at UHD routinely perform Brooklyn firsts. As recently as four months ago, the American College of Surgeons

recognized the UHD surgical service for outstanding outcomes, placing it among the top 11% of U.S. hospitals for risk-adjusted surgical outcomes, alongside elite institutions such as Brigham and Women's Hospital, Memorial Sloan Kettering, Mayo Clinic, and Mount Sinai. This distinction reflects UHD's commitment to clinical excellence, precision, safety, and patient-centered care. We cannot possibly recruit or retain such talented faculty in a community hospital setting.

UHD physicians are committed beyond their clinical practice and have contributed greatly to the scientific community through their research and teaching; this cannot stop while we create a new facility. UHD faculty hold membership and leadership positions in national and international societies; sit on federal grant sections and editorial boards for scientific journals; and provide lectures locally, regionally, and nationally. For example, several current or recent Downstate Chairs have served as presidents of national and regional medical societies, and one was recently elected to the Board of Governors of the American College of Physicians. Three Chairs hold multimillion-dollar grants and run innovative, large-scale clinical studies that promise to transform practice and healthcare delivery. One sits on a committee of the Accreditation Council for Graduate Medical Education (ACGME), helping to shape the national objectives of graduate medical education and training of future physicians. UHD faculty are the reason the COM is one of the largest GME-sponsoring institutions in New York and has the largest number of trainees and students who stay and work in New York State. 60% of the clinical teaching of our medical students in the COM is done by UHD faculty. This defines academic medicine, and only UHD can preserve that for the hospitals, schools, and colleges that depend on the service of UHD physicians. UHD faculty, through the COM, serve as the academic affiliate faculty for many additional hospitals in the borough of Brooklyn. While we share the utmost respect for our colleagues at Kings County Hospital, it is essential to recognize that Kings County Hospital is primarily service-oriented and does not serve as an academic institution; thus, it does not attract doctors invested in academic medicine. In addition, Kings County Hospital has markedly cut back on the number of Downstate COM student rotation slots in favor of students from an international medical school that does not have Liaison Committee on Medical Education (LCME) accreditation. From a clinical perspective, Kings County Hospital cannot absorb the additional patients from UHD in either a transitional plan or a permanent merger.

**Responses to the questions raised by the DCAB on the above proposal on February 28, 2025, during their special session with the Chairs. The questions are phrased as we heard them.**

1. **What made you revise your statement from phased renovation to a new building?**
   Our initial proposal was submitted based on the information that Governor Hochul had agreed to $300 million in capital funding to modernize and revitalize UHD. The Chairs focused on what $300 million could achieve. Given the experience with the renovation of current nursing station 82 by *Constructomics*, we believed a phased renovation consideration was possible, albeit only for selected clinical areas. Following the increase in committed funds to $750 million, it became possible to envision a better UHD for the generation to come. We are, however, not entirely opposed to a phased renovation that would essentially transform the entirety of inpatient services, not only the "selected clinical areas." Again, we leave these decisions to the experts.

2. **Which block will a new building be on, and how will that be connected to the old building?**
   We leave the location of the new edifice and/or modernized renovation of the current building to those with the working knowledge of construction and budgetary constraints. We ask only that our patients acquire access to the modern services that affluent

hospitals in less disadvantaged neighborhoods of NYC have access to. We believe our patients also deserve the quality of experience afforded by these facilities.

3. **Do you see any efficiencies with Kings County Hospital?**

We currently have physician specialists who are employed by UHD and also provide care at Kings County Hospital (KCH), but when their patients need interventions or procedures, they are transferred to another hospital outside our community, displacing patients' care far from their homes. For example, UHD and Kings County Hospital together have enough cardiac volume to keep a cardiothoracic center active at UHD, as it once was, to serve the local community and for the benefit of our learners. Instead, these patients are transferred out, often to Bellevue, which is a disservice and an inconvenience. Why should family members of a sick patient in central Brooklyn travel to a Manhattan hospital to visit their relatives when care could have been provided locally? This additionally deprives our trainees of complex educational training. Care that can be provided locally between the two hospitals should be identified in the revitalization plan and maintained through a professional service agreement. We also see our Emergency Departments as complementary, with KCH as the Level 1 Trauma Center and UHD providing complex medical care as described below. There are opportunities to regionalize Pathology with UHD and Maimonides using digital pathology, which would allow subspecialty diagnostic care and also keep more lab test processing within Brooklyn instead of sending to for-profit reference laboratories.

4. **How should the ED be envisioned? Should we have emergency services at Downstate?**

Our Downstate Emergency Department (ED) is open to care for all who enter our hospital doors, caring for approximately 47,000 adult and pediatric patients per year, providing acute, critical, and urgent care to our diverse patient population. As EDs all over the city battle with boarding (the practice of keeping patients in an ED while waiting for an inpatient bed to become available), overcrowding, and fluctuating volumes, our services at Downstate are vital for the community and need to be expanded. During peak viral season (September–March), UHD boards on average 15 to 20 patients per day. In comparison, during the same time period, Kings County Hospital was boarding approximately 60 to 70 patients per day, One Brooklyn Health Brookdale 35 to 45 patients per day, and Maimonides 40 to 60 patients per day. From January 2024 to February 2025, the average boarding time at Kings County Hospital was 34 hours. The closure of both Mt. Sinai Beth Israel and Kingsbrook Jewish has left NYC communities underserved. Closing another ED in an already medically underserved community would have devastating impacts on the surrounding EDs, which already struggle to care for the volume of patients seen. Emergency departments all across the nation have broadened their scope of practice to serve not only the emergent needs of patients but also their urgent care needs and, more important, to act as the first access point for patients into the healthcare system, connecting them to primary and specialty care. Several local facilities have renovated and expanded their emergency departments, including NYC H+H South Brooklyn Hospital, Richmond University Hospital, Maimonides Hospital, and St. John's Episcopal Hospital. UHD ED sees, on average, 150 patients per day, 20% of whom are admitted to the hospital. The ED is an important access point to UHD and is essential for the success and growth of other hospital services. Expanding the UHD ED floor plan will allow us to better serve our patients and improve the quality of the high-

acuity medical and critical services we currently provide. We could meet the medical needs of patients displaced from overcrowded surrounding hospitals and optimize the care, with shorter boarding times and broader scope of practice, of community members who routinely seek care at UHD. The UHD ED should obtain Level 3 ACS Trauma certification and can continue to partner with KCH to provide a higher level of trauma care at their facility. In contrast to KCH, UHD cares for higher acuity patients, with more complex co-morbidities, requiring more critical care needs and greater resources while in the ED. Opening an Emergency Department Observation Unit—which literature has shown aids in addressing ED overcrowding, prevents avoidable admissions (particularly hospitalizations of less than 48 hours), and optimizes hospital resource utilization while managing rising healthcare costs—would help to shorten our patients' lengths of stay, lower hospital costs, and lower admission rates. An expanded UHD ED would be the foundation of a modern and revitalized hospital, and is aligned with Governor Hochul's plan to create "a sustainable plan that ensures SUNY Downstate continues to deliver healthcare in its community and train a diverse healthcare workforce for generations to come."

**5. Why have you sought chiefs from Maimonides for cardiology and oncology?**

In 2017, the Downstate Chair of Neurology was asked to lead a regional department for Downstate and Maimonides. In 2018, the Downstate Chair of Pathology was asked to lead the Pathology and Laboratory Department for Maimonides. These relationships grew from the strong affiliation of the medical school with Maimonides. Seeing the success of these two regional departments and the strong partnership between the institutions, UHD sought chiefs for cardiology and oncology when vacancies were difficult to fill due to the chronic disinvestment at UHD. In 2017, UHD closed its Radiation Oncology service when leadership at the time decided the $3 million needed to upgrade the HVAC system for installation of a new radiation machine (LINAC) and purchase the LINAC itself was not justified given fiscal constraints. The entire division of Radiation Oncology, including the chief, faculty, technicians, nurses, staff, and residency program, was enucleated. The New York State Department of Health did not close the program, though, and the program could be rebuilt if UHD has the funding support to do so. However, without the full spectrum of oncological services including radiation oncology, the Chief of Hematology and Oncology left UHD and no academic medical oncology chief would accept the job. Aligning with Maimonides and their Cancer Center services through their Chief of Oncology made sense given the relationship of Maimonides and Downstate for Neurology and Pathology. But the closure of the Radiation Oncology division has had a rippling negative impact on Hematology, Gynecologic Oncology, and other subspecialty surgical services. Patients must be referred outside the health system and travel long distances to receive complete oncologic and radiation care. A revitalization plan *MUST* include radiation oncology to keep specialized cancer care for our patients close.

In 2019, UHD decided to *voluntarily* close the Cardiothoracic service and remove the Chief of Cardiothoracic Surgery due to outcomes. The infrastructure of perfusionists, nurses, physician assistants, and other support staff either left or were reassigned, and leadership made the decision not to reestablish the program due to funding. Since DOH did not close the program, the program could be rebuilt if UHD has the funding support to do so. In order to have the full spectrum of cardiac services including cardiothoracic surgery, the Department of Medicine had no choice but to align with Maimonides

Hospital Cardiothoracic services through its Chief of Cardiology, who now serves as the Chief at UHD until the program is reestablished. The absence of cardiothoracic surgery is a serious deficiency that has diminished the level of cardiac care we can provide for our patients, who have a high prevalence of cardiac illnesses. Essentially, all major cardiac cases are transferred out of UHD to Maimonides or other hospitals. A revitalization plan *MUST* include Cardiothoracic Surgery and a strong realignment with Kings County Hospital to keep these cases at UHD and in the community.

6. **There is a lot of leakage; why can't we keep the patients in the Downstate system?**

   Chronic underfunding has created the problem of leakage from UHD. Faculty and staff who resign and retire are not being replaced in a timely manner to continue services. When vacancies cross budget years, salary lines may disappear from the budget and the process to reinstate them is almost impossible, despite the fact that these positions were vacated and need to be refilled to continue services. While removing these lines from the budget to "close the deficit" makes the hospital's bottom line look better, it is not in the service of our patients or community. Patients don't want to wait for months to be scheduled for a clinic visit. The number of FTE performing specialty tasks is critically low and cannot possibly provide the full range of services needed to retain services at UHD and prevent leaks. Clinical programs have also been reduced or terminated purely for financial reasons, leaving patients and doctors to seek alternative care elsewhere. The loss of Cardiothoracic and Radiation Oncology services, the biggest revenue-generating service lines for any hospital, has created significant service gaps. For instance, all patients presenting with spinal cord compression, head and neck tumors, and other solid cancers requiring radiation are transferred to other hospitals that can provide concurrent radiation and chemotherapy. In addition, in some instances, equipment breakdowns, such as MRI or cardiac catheterization equipment, could take days to resolve.

7. **In order of preference, which one comes first: renovation, new hospital, move to another facility?**

   Our priority is to provide the high-quality care our community deserves. We understand the financial constraints of UHD and of New York State; however, we implore the Community Advisory Board and the Governor to consider the needs of the community when making these financial decisions. We have seen a chronic disinvestment in our hospital and the healthcare of our community, which has further exacerbated healthcare disparities impacting our at-risk patient population. We strongly believe that our patient population, no matter their income, lack of privilege, or ethnic and racial makeup, deserve the same high level of care in a modernized center that patients in more affluent neighborhoods of NYC are being provided. While our opinion on what the edifice should be is beyond our expertise, we look forward to working with consultants, contractors, and development managers to build clinical operations and service lines that we know our patients need. In order for us to have a sustainable plan for Downstate, we cannot be deprived of the much-needed specialized care our patients require. A revitalization plan *MUST* include services that have been diminished over the years, including Cardiothoracic Surgery, Radiation Oncology, and Gynecologic Oncology. It is also important that the only medical school in a borough of 2.9 million people should have a modern, academically oriented hospital that maximizes the education of future doctors

and other healthcare professionals, and focuses on addressing the healthcare disparities of our community.

**SUMMARY:** Working collaboratively with our community-based organizations, elected officials, and union representatives, we are ready to do the important work of aligning the needs of Central Brooklyn patients with the services of a modernized hospital that provides the full range of tertiary care services our patients deserve. Our patients should not cross the bridge to Manhattan hospitals when UHD can offer the same care closer to their homes.

Sincerely,

Chairs of Downstate Health Sciences University College of Medicine

(*in alphabetical order by last name)*

Sydney C. Butts, MD, FACS
Interim Chair and Professor, Department of Otolaryngology
Chief, Facial Plastic and Reconstructive Surgery

Mudar Dalloul, MD
Interim Chair and Professor of Clinical Obstetrics and Gynecology
Director of Grand Rounds and Faculty Development
Department of Obstetrics and Gynecology

Dennis Dimaculangan, MD
Interim Chair, Department of Anesthesiology
Clinical Associate Professor of Anesthesiology

Enitza D. George, MD, MBA, MSAI
Chair, Department of Family and Community Medicine
Associate Professor of Clinical Family and Community Medicine, SUNY Downstate Health Sciences University
Chief Population Health Officer, University Hospital at Downstate

Sharon A. Glick, MD, MS
Chair, Department of Dermatology
Program Director, Department of Dermatology Professor of
Clinical Dermatology and Pediatrics

Panos Kougias, MD, MSc
Chair, Department of Surgery
Clarence and Mary Dennis Professor of Surgery

Jenny Libien, MD, PhD
Chair, Department of Pathology
Professor of Clinical Pathology and Neurology

Deborah L Reede, MD

Professor and Chair, Department of Radiology

Christopher Román, Ph.D.
Chair, Department of Cell Biology
Associate Professor of Cell Biology and Medicine

Daniel M. Rosenbaum, MD
Distinguished Service Professor and Chair,
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Moro Salifu, MD, MBA, MPH, MACP
Professor and Chair, Department of Medicine
Director and PI, Brooklyn Health Disparities Center (BHDC)
Chair, Clinical Chairs Group

Roman Shinder, MD FACS
Interim Chair of Ophthalmology
Professor of Ophthalmology, Otolaryngology Director of
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Teresa Y. Smith-Bellille, MD, MSEd, FACEP
Interim Chair, Department of Emergency Medicine
Associate Dean of Graduate Medical Education and Affiliations, Professor
of Clinical Emergency Medicine

Ramaswamy Viswanathan, MD, DrMedSc
Professor and Interim Chair, Department of Psychiatry and Behavioral Sciences
Senator, SUNY Faculty Senate

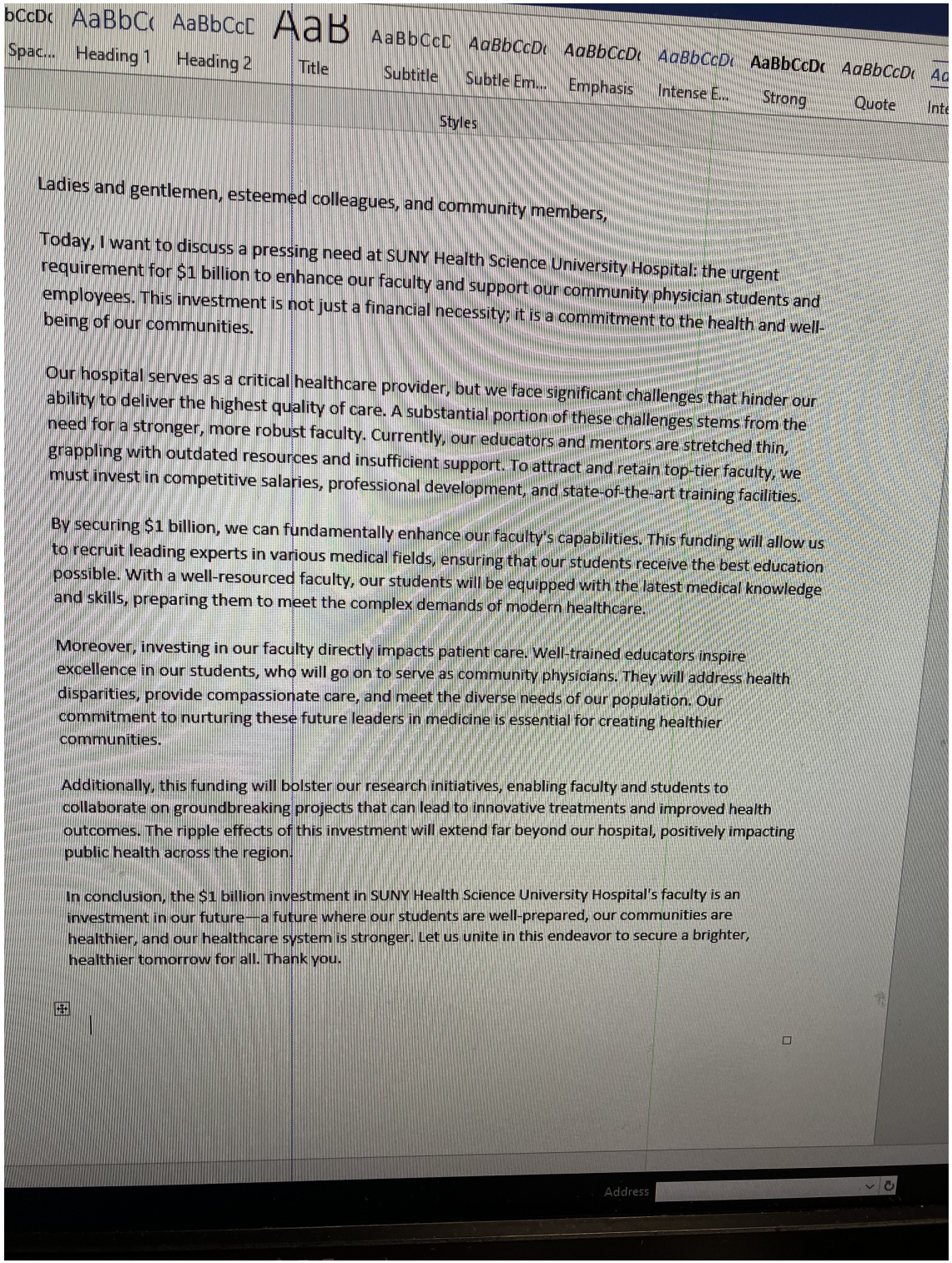
Stephen Wadowski, MD
Professor and Chair, Department of Pediatrics

Jeffrey P. Weiss, MD, PhD, FACS
Professor and Chair, Department of Urology
Director, MD-PhD Program, School of Graduate Studies

David Wlody, M.D.,
Chair Emeritus, Department of Anesthesiology
Professor Of Clinical Anesthesiology
Past Chair of Downstate Clinical Chairs Group
Past President, Society for Obstetric Anesthesiology and Perinatology

William Urban, MD
Chair, Department of Orthopedics Associate
Professor of Orthopedics

Robert K. S. Wong, PhD
Distinguished Professor and Chair, Department of Physiology and Pharmacology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Ladies and gentlemen, esteemed colleagues, and community members,
Today, I want to discuss a pressing need at SUNY Health Science University Hospital: the urgent requirement for $1 billion to enhance our faculty and support our community physician students and employees. This investment is not just a financial necessity; it is a commitment to the health and well-being of our communities.
Our hospital serves as a critical healthcare provider, but we face significant challenges that hinder our ability to deliver the highest quality of care. A substantial portion of these challenges stems from the need for a stronger, more robust faculty. Currently, our educators and mentors are stretched thin, grappling with outdated resources and insufficient support. To attract and retain top-tier faculty, we must invest in competitive salaries, professional development, and state-of-the-art training facilities.
By securing $1 billion, we can fundamentally enhance our faculty's capabilities. This funding will allow us to recruit leading experts in various medical fields, ensuring that our students receive the best education possible. With a well-resourced faculty, our students will be equipped with the latest medical knowledge and skills, preparing them to meet the complex demands of modern healthcare.
Moreover, investing in our faculty directly impacts patient care. Well-trained educators inspire excellence in our students, who will go on to serve as community physicians. They will address health disparities, provide compassionate care, and meet the diverse needs of our population. Our commitment to nurturing these future leaders in medicine is essential for creating healthier communities.
Additionally, this funding will bolster our research initiatives, enabling faculty and students to collaborate on groundbreaking projects that can lead to innovative treatments and improved health outcomes. The ripple effects of this investment will extend far beyond our hospital, positively impacting public health across the region.
In conclusion, the $1 billion investment in SUNY Health Science University Hospital's faculty is an investment in our future—a future where our students are well-prepared, our communities are healthier, and our healthcare system is stronger. Let us unite in this endeavor to secure a brighter, healthier tomorrow for all. Thank you.
Address

**Testimony on the Importance of Keeping SUNY Downstate Medical Center**

As a cornerstone of healthcare in Brooklyn and a beacon of equity in medicine, SUNY Downstate Medical Center is irreplaceable for the communities it serves. Its continued operation is essential, not only for its unparalleled commitment to diversity and inclusion but also for its unique, life-saving kidney transplant services that address the needs of New York's most vulnerable populations.

SUNY Downstate Hospital has played a crucial role in Central Brooklyn, especially for Black and Caribbean communities. It has historically provided quality care, innovative research, and vital services, often serving as a safety net when other hospitals were overburdened. However, financial instability and a wave of hospital closures - often in predominantly Black neighborhoods - now threaten Downstate's future. Closing hospitals like Downstate would mean a loss of healthcare access and jobs, accelerating gentrification and displacement. Instead of closures, we should reimagine Downstate's mission by maintaining inpatient beds and emergency services, and developing specialized research and primary care hubs, ensuring the hospital continues to serve the community's evolving needs. (Edwards, 2024)

**Demographic Impact and Diversity Leadership**

SUNY Downstate stands out as one of the most diverse academic medical centers in the nation. As of Fall 2023, 65% of its 2,204 students come from diverse backgrounds, with the student body comprising 27% White, 25% Asian, 24% Black, and 13% Hispanic individuals (Riley, 2024). The institution ranks in the 93rd percentile nationally for total African American graduates and the 92nd percentile for total underrepresented minorities in medicine becoming faculty (Downstate, 2025). In addition, 68% of all students are minorities, and 36% are Brooklyn residents, reflecting the rich diversity of the borough and the city (Downstate, 2025). This commitment extends to the faculty, where 533 are Black or African American, making Downstate a leader in training and employing minority healthcare professionals (CDAT, 2025).

**Unique and Essential Kidney Transplant Services**

SUNY Downstate operates Brooklyn's only academic medical center and is the only hospital in the borough offering transplant surgery (Riley, 2024). Its kidney transplant program is a lifeline for the borough's diverse and often marginalized populations. According to recent data, Downstate transplants the highest percentage of Medicaid and minority patients in New York

City: 31.7% of transplant recipients are Medicaid beneficiaries, and 98.3% are people of color (Riley, 2024). Nearly all patients receiving transplants at Downstate suffer from kidney failure due to diabetes or hypertension-conditions that disproportionately impact minority and low-income communities (Riley, 2024).

The program is recognized for its innovation and inclusivity. Downstate pioneered several transplant procedures in New York, including the first kidney-pancreas and dual kidney transplants, and was among the first in the nation to perform laparoscopic kidney removal from living donors (Downstate, 2025; Rochon & Suresh, 2025). In 2018, it became the first institution to perform a kidney transplant from a living donor after the patient had previously undergone a living donor intestinal transplant (Rochon & Suresh, 2025). The program's use of "overlooked kidneys"-organs that other centers might reject-has expanded access and reduced wait times for patients who would otherwise face years on dialysis (Riley, 2024).

**Outcomes and Community Impact**

The effectiveness of Downstate's kidney transplant program is evident in its outcomes. For the past two years, patient survival and post-surgical kidney function rates have outperformed the national average, and the mortality rate for patients on the waitlist is among the lowest in the country (Riley, 2024). The program's comprehensive approach includes rigorous donor and recipient assessment, meticulous matching, and dedicated post-transplant care, ensuring the best possible results for every patient (Riley, 2024; Rochon & Suresh, 2025).

Furthermore, Downstate's reach extends beyond the hospital walls. It provides free health screenings, educational programs, and community health initiatives that serve thousands of Brooklyn residents annually (Downstate, 2025). Its pipeline programs inspire and prepare students from underrepresented backgrounds to pursue careers in health, ensuring a future workforce that mirrors the community it serves (Downstate, 2025).

**Conclusion**

Closing SUNY Downstate would not only eliminate a critical source of advanced medical care for Brooklyn's diverse communities but also dismantle a program that is nationally recognized for its equity, innovation, and outcomes in kidney transplantation. Downstate is more than a hospital; it is a model of health justice, a training ground for the next generation of diverse

healthcare leaders, a community collaborator and a lifeline for patients who have historically been excluded from specialty care (Riley, 2024; Joseph & Adler, 2024). Why not listen to the Doctors, Nurses, Staff, Patients, and community members; past and present, who have rallied with stories of the value of Downstate bringing along their recommendations and proposals for how to make SUNY Downstate viable? Its continued presence is vital for the health and well-being of Brooklyn and beyond.

**References:**

Downstate, SUNY, (2025). *About Our Program | Transplant Services | Downstate Health*

Downstate, SUNY, (2025). *Fast Facts | SUNY Downstate Health Sciences University*

College Data Analytics Team, (2025). *SUNY Downstate Health Sciences University Diversity: Racial Demographics & Other Stats*

Edwards, K., (2024). *Op-ed | The state of healthcare in Central Brooklyn • Brooklyn Paper*

Joseph, N & Adler, K. A., (2024). *OP-ED: Closing SUNY Downstate would be a disaster*

Riley, W., (2024). *Downstate's Kidney Transplant Program | President's Bulletin | SUNY Downstate Health Sciences University*

Riley, W., (2024). *Downstate's 2023 Student Data Now Available | President's Bulletin | SUNY Downstate Health Sciences University*

Rochon, C. & Suresh, S. C., (2025). *Transplant Division | University Hospital at Downstate | SUNY Downstate*

Outlook

## Consultants

**From** Deborah Pointer <Deborah.Pointer@downstate.edu>
**Date** Thu 5/1/2025 11:20 AM
**To** Public Hearing <publichearing@adenaconsultinggroup.com>

There seems to be a significant increase in consultants on this project. How are they being paid? Is this coming from the state money? Thank you.

Deborah Pointer, M. Ed (718-270-1694)
Pediatric Fellowship Program Coordinator
(Staff member at SUNY Downstate for over 30 yrs.)
Member of Community Bd. 17

Sadly, the financial landscape has changed so dramatically since its inception that the committee must examine possibilities that are "out of the box"

The governor has unfortunately not yet embraced this principle -
creating a budget with a sizable increase in Medicaid and Medicare costs at a time when the Federal government is announcing massive cutbacks in these programs has very little possibility of being appropriated

The new Federal fiscal policy most dramatically impacts those that are most vulnerable- our patients-as reflected in pandemic outcomes in our zip codes.

We have been maimed, crippled, suffocated, and most dramatically ignored for decades and are a mere shell of what we were and we can't deny this. Our deficiencies are glaring and are obvious to any objective evaluator. So dreaming about 1 billion dollars to build a new facility to replace an entity that has inadequate faculty, inadequate staff, that has been stripped of essential core programs that generate top end revenue is not an attractive investment.

I suggest creating the comprehensive Kings Count Health Science University that is dedicated to consolidating care between the present UHB, Kings County, Brookdale, Interfaith and Kingsbrook with agreements in place that will require out faculty and senior nurses and ancillary staff from the public health schools to be assuming primary responsible for improving quality throughout the new affiliated system.

The investment will create multiple neighborhood satellites that will be supervised by Downstate faculty that focus on readily available continuity care, vaccine compliance, preventive health screening, and promotion of healthy lifestyles during the day that become local urgicenters with radiology capabilities after hours. Imaging will be interpreted by off-site Downstate faculty radiologists. A transportation. system will bring blood and other samples to the central laboratories.

The new downstate will be smaller and will focus on high end care for the 1,000,000 individuals who live in our area and who will be served locally through the same system. State of the art facilities will provide cardiology including cardiothoracic surgery / comprehensive cancer with radiation oncology / comprehensive surgical subspecialty services for adults and children including neurosurgery and orthopedic surgery and transplantation

The recommended presentation to the governor should focus on four central tenets

1.there are over 1 million vulnerable people who will go from underserved to state-of-the-art care
2. the largest suppliers of future NYC physicians will have better training than they have had for decades
3 students at one of the largest medical schools in the country will again benefit from complex cases and engaged faculty as they rotate and observe high end and community medicines delivered in a culturally sensitive way to a diverse population
4. Given the present financial atmosphere – this program will SAVE money by
   a. reducing redundancy
   b. improving quality throughout the system
   c. ultimately diminishing advanced disease states and unnecessary ER visits, hospitalizations and ICU admissions by focusing on prevention and early detection of diseases with better compliance to therapeutic programs

Of course, it is possible that we may wind up with a mayor and a governor who hate each other, and a president without any compassion. Having a plan that is thoughtful and compelling can be brought to the legislature, to the media, and to the community to gain support and force the politician's hands

April 24, 2025

Esteemed Advisory Board members,

I am Chella Kamarajan, serving as Assistant Professor of Psychiatry at SUNY Downstate Health Sciences University. I am also part of the renowned Neurodynamics Laboratory, which has been receiving continuous NIH funding over the last 50 years to do cutting edge research on addiction, neuroscience, and genetics.

FYI, I attended the last three hearings of the Downstate Community Advisory Board (DCAB), and I am now submitting this testimony for the fourth hearing to be held on April 28, 2025. I do understand that the focus of the hearing has moved from "whether to modernize and revitalize" to "how to modernize and revitalize". Now is the time, we should seriously analyze and sort out all the ideas and plans collected so far and also consider other suggestions that will be collected from all stakeholders in the coming days and weeks so that we will soon arrive at a concrete plan for our goal of revitalizing and modernizing our Downstate, a historic institution.

To achieve this goal in the coming days and weeks, I would strongly advocate to the advisory board that it must consider the modernization plan proposed by the clinical chairs of SUNY Downstate as the first priority. As you most of you know, the clinical chairs shared their vision to modernize Downstate in their first letter on October 08, 2024. Then recently, as of February 26, 2025, the chairs have updated their plan in their revised letter. I am of the understanding that both of these letters have been already submitted to the advisory board for consideration.

The main reason for me to firmly emphasize the point that it is very important to examine and follow the chairs' plan and vision is that it is the clinical chairs who know the current status as well as future needs of the hospital so well, as they dedicatedly serve the hospital on a day-to-day basis. On the other hand, I must also admit that although the chairs' letters emphasize the modernization plan on the facility, infrastructure, and clinical services in broad terms, it does not list all necessary items and details with attached dollar amounts. The chairs may further need to collect opinions and ideas from Downstate's staff and faculty members for additional inputs, while also seeking additional help to estimate dollar amounts for each project item from the engineering department, so that their proposed plan becomes more elaborate, representative, and realistic.

Finally, I would like to end my testimony with this note. Recently, I had a chance to read an op-ed written by Chanceller King over five months ago (on December 13, 2024) which reads, I quote, "Downstate is not just an institution, it is a community of leaders, and we must ensure a path forward that enables leaders like these to continue to flourish" (Ref:

https://www.caribbeanlife.com/a-new-path-forward-for-downstate-suny/). I sincerely thank Chanceller King for this visionary statement and of course all the board members for their committed efforts to revive and revitalize Downstate. Thank you all.

Sincerely,

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Sadly, the financial landscape has changed so dramatically since its inception that the committee must examine possibilities that are “out of the box”

The governor has unfortunately not yet embraced this principle -
creating a budget with a sizable increase in Medicaid and Medicare costs at a time when the Federal government is announcing massive cutbacks in these programs has very little possibility of being appropriated

The new Federal fiscal policy most dramatically impacts those that are most vulnerable- our patients-as reflected in pandemic outcomes in our zip codes.

We have been maimed, crippled, suffocated, and most dramatically ignored for decades and are a mere shell of what we were and we can’t deny this. Our deficiencies are glaring and are obvious to any objective evaluator. So dreaming about 1 billion dollars to build a new facility to replace an entity that has inadequate faculty, inadequate staff, that has been stripped of essential core programs that generate top end revenue is not an attractive investment.

I suggest creating the comprehensive Kings Count Health Science University that is dedicated to consolidating care between the present UHB, Kings County, Brookdale, Interfaith and Kingsbrook with agreements in place that will require out faculty and senior nurses and ancillary staff from the public health schools to be assuming primary responsible for improving quality throughout the new affiliated system.

The investment will create multiple neighborhood satellites that will be supervised by Downstate faculty that focus on readily available continuity care, vaccine compliance, preventive health screening, and promotion of healthy lifestyles during the day that become local urgicenters with radiology capabilities after hours. Imaging will be interpreted by off-site Downstate faculty radiologists. A transportation. system will bring blood and other samples to the central laboratories.

The new downstate will be smaller and will focus on high end care for the 1,000,000 individuals who live in our area and who will be served locally through the same system. State of the art facilities will provide cardiology including cardiothoracic surgery / comprehensive cancer with radiation oncology / comprehensive surgical subspecialty services for adults and children including neurosurgery and orthopedic surgery and transplantation

The recommended presentation to the governor should focus on four central tenets

1.there are over 1 million vulnerable people who will go from underserved to state-of-the-art care
2. the largest suppliers of future NYC physicians will have better training than they have had for decades
3 students at one of the largest medical schools in the country will again benefit from complex cases and engaged faculty as they rotate and observe high end and community medicines delivered in a culturally sensitive way to a diverse population
4. Given the present financial atmosphere – this program will SAVE money by
   a. reducing redundancy
   b. improving quality throughout the system
   c. ultimately diminishing advanced disease states and unnecessary ER visits, hospitalizations and ICU admissions by focusing on prevention and early detection of diseases with better compliance to therapeutic programs

Of course, it is possible that we may wind up with a mayor and a governor who hate each other, and a president without any compassion. Having a plan that is thoughtful and compelling can be brought to the legislature, to the media, and to the community to gain support and force the politician's hands

Downstate Public Hearing Comments

We thank the advisory board for their efforts on charting a future path for Downstate. As the Chief of Pulmonary and Critical Care at Downstate, I agree with the plan put forth by the Chairs to create specialized programs in obstetrics/neonatal care, cardiovascular disease, oncology transplant and emergency medicine. The community needs these services. However, in order to connect the patients to the services we need to build an ambulatory care center with a parking lot to make it accessible for our community. We need great inpatient services but they will wither on the vine unless we connect patients in the community to them. Having a large outpatient practice attached to the hospital will facilitate this process. A key will be to establish large primary and specialized care practices within the ambulatory center. Potentially, we could offer space to community physicians at a low cost which will increase the number of primary care practices in the community and provide referrals to our specialized inpatient services. In addition, we should coordinate with other Brooklyn hospitals to refer patients to us for the specialized services we offer. Maintaining a vibrant medical center at Downstate will have multiple benefits for the community and state. For one, it will improve the quality of medical care for the people of Central Brooklyn. Secondly, it will maintain Downstate as one of the most important medical training centers in New York State. Lastly, keeping these services in this community will provide well-paying jobs that improve the economic well-being of our region.

My name is Sophia Zweig, and I am a fourth year medical student. I care deeply about my patients at Downstate and I am a resident of the neighborhood (NY District 9).

Taking away inpatient services will strip students of essential hands-on experiences that are fundamental to learning how to care for patients safely and effectively. Inpatient training is where students learn to manage critically ill patients, respond to emergencies, coordinate complex care– lessons that cannot be fully taught in outpatient clinics alone. Without access to inpatient experiences, we risk graduating doctors who are less prepared, confident, and ultimately capable of providing high quality care. Protecting inpatient services means protecting the future of healthcare itself.

Most importantly, sending our hospitalized patients to other hospitals– with unclear plans for making space in those hospitals and no money for hiring extra staff for them– will be a detriment to our patients, many of whom cannot walk more than a few blocks away due to their health.

My asks are the following:

1. First: The Intensive Care Unit (ICU) is where patients with serious or life-threatening illnesses receive critical care. Currently patients are separated by curtains, not walls, risking infections spreading between the illest patients in the hospital. This goes against the recommendations of the Society of Critical Care Medicine Guidelines. And our critically ill patients and their families deserve more dignity than this.
2. Second: Renovate and remodel maternity services to reflect patient need - Maintain Regional Perinatal Center - one of only TWO in Brooklyn - Single occupancy rooms
3. Third: more radiology equipment!! I have seen multiple patients be kept for days longer than necessary in the hospital because they are waiting for an x-ray, CT scan, etc.
4. Fourth: An automated appointment reminder system for patients via text/call. Countless patients tell me that it’s impossible to reach our scheduling department. Many miss important appointments – sometimes cancelled without notifying – or patients forget without reminders (and our patients deal with difficult challenges outside of health). This will significantly help decrease patient no-shows and increase efficiency.
5. Fifth: Buy new BP monitors for the primary care clinic (Suite B); many do not work at

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