

**DR. JO IVEY BOUFFORD**

00:00:02:15 This is quite a production here. This is quite a production. My god. Hi.  
How are you?

**EDEMIR CASTANO**

00:00:08:12 Hi. It's nice to meet you.

**DR. JO IVEY BOUFFORD**

00:00:09:03 Hi. Your name is?

**EDEMIR CASTANO**

00:00:09:22 Edemir.

**DR. JO IVEY BOUFFORD**

00:00:10:14 Anamere. Hi.

**MAHEEM WELCOME**

00:00:11:11 Hi. Maheem.

**DR. JO IVEY BOUFFORD**

00:00:12:06 You're all very illustrious. I've read your bios.

**BELLA**

00:00:13:06 Hi. I'm Bella.

**DR. JO IVEY BOUFFORD**

00:00:14:03 Yeah, indeed. Hi.

**OLIVIA FEAL**

00:00:16:14 Hi. I'm Olivia.

**DR. JO IVEY BOUFFORD**

00:00:17:11 Olivia. Good.

**OLIVIA FEAL**

00:00:17:22 Nice to meet you.

**CARLOS GALINDO**

00:00:18:22 Good morning. Nice to meet you. Carlos.

**DR. JO IVEY BOUFFORD**

00:00:19:22 Good morning. Hi. How are you?

**OLI ISLAM**

00:00:20:00 Hi. Oli Islam.

**DR. JO IVEY BOUFFORD**

00:00:20:22 Nice to meet you.

**WEILY LANG**

00:00:22:01 I'm Weily. Good morning.

**DR. JO IVEY BOUFFORD**

00:00:22:19 How are you?

**RICHARD K. LIEBERMAN**

00:00:23:16 I'm here to make sure you don't trip over the wire.

**DR. JO IVEY BOUFFORD**

00:00:25:14 Oh, yeah. Okay.

[Laughter]

**UNIDENTIFIED MALE**

00:00:28:20 Hi.

**DR. JO IVEY BOUFFORD**

00:00:29:00 Hi.

**RICHARD K. LIEBERMAN**

00:00:34:08 Well, thank you so much for –

**DR. JO IVEY BOUFFORD**

00:00:35:00 These are observers? Are they spies?

**RICHARD K. LIEBERMAN**

00:00:37:00 Oh, these are – come over. These are definitely spies. This is faculty.

[Introductions to faculty]

**DR. JO IVEY BOUFFORD**

00:00:52:09 So when did you – oops. Oh, sorry. Do you want to do this? When did you get the archives, the oral history records from Columbia? Did they transfer them over?

**RICHARD K. LIEBERMAN**

00:01:03:21 Oh, Columbia? Actually, Koch made that deal for us. He told them to give us copies of every one.

**DR. JO IVEY BOUFFORD**

00:01:11:15 Oh, cool. Well, that's nice, yeah, because he hadn't really done anything for a while.

**RICHARD K. LIEBERMAN**

00:01:14:18: You know him. He makes the call. They do it.

**DR. JO IVEY BOUFFORD**

00:01:16:03 Yeah, yeah, yeah. Absolutely. No, that's great.

**UNIDENTIFIED FEMALE**

00:01:18:09 [Inaudible] mike in front of you?

**RICHARD K. LIEBERMAN**

00:01:20:14 Do you want a mike? Oh, you want me to do it? Hello, everybody.  
[Laughter] Jo, thank you so much for having us here.

**DR. JO IVEY BOUFFORD**

00:01:28:14 You're welcome. Thanks for coming.

**RICHARD K. LIEBERMAN**

00:01:28:23 It's really a treat for us. Just for the camera, I'm Richard Lieberman and the director of LaGuardia & Wagner Archives. And we have the Koch Papers at LaGuardia. And Jo, the reason we're here is – and you'll understand this. About two years before the mayor died, he talked to me about his legacy and what he wanted. And he said what he wanted was young people to be interested in government.

**DR. JO IVEY BOUFFORD**

00:01:54:14 Great. Nothing better than that.

**RICHARD K. LIEBERMAN**

00:01:58:08 And he said, "Go figure it out." [Laughter] And what we came up with with him was we would invite some of the honor students at LaGuardia to participate in a one-year program where we research a topic to be defined by the students and by the faculty and that we get involved in researching his papers, the video, the documents, and also that we interview the people who are involved in policy in that topic.

**DR. JO IVEY BOUFFORD**

00:02:27:03

Great. Oh, good.

**RICHARD K. LIEBERMAN**

00:02:28:15

And so the first year, we did housing in a fiscal crisis. Last year, we looked at race and particularly Sydenham. And this year, our focus is public health, and right now our focus is on AIDS. And we may move beyond AIDS.

**DR. JO IVEY BOUFFORD**

00:02:44:05

Hopefully. [Laughs] [Inaudible]. Yeah, okay.

**RICHARD K. LIEBERMAN**

00:02:48:11

Right now, it's AIDS. Then, at the end of the year, we have a party at the *New York Times*. The students come. We invite people to interview. We have a panel discussion about the topic of what we learned this year. And all the Koch people show up. We have about 150 people [inaudible].

**DR. JO IVEY BOUFFORD**

00:03:05:11

Oh, very cool. Yeah, I try to go to the birthday party every year, but the dates haven't been great for me the last couple of years. Capalino always gives me a hard time [inaudible].

**RICHARD K. LIEBERMAN**

00:03:14:17

So that's the background, and that's why we're here. We've been researching. They have questions; we've been studying; we've been rehearsing; we're nervous. I mean we're everything. [Laughter]

**DR. JO IVEY BOUFFORD**

00:03:23:05

I'm nervous. [Laughter]

**RICHARD K. LIEBERMAN**

00:03:25:15

So the way we like to begin is ask you to say your name, introduce yourself, and what role you played in the Koch Administration.

**DR. JO IVEY BOUFFORD**

00:03:34:03

Jo Boufford. I'm president of the New York Academy of Medicine now, and I was the president of the New York City Health and Hospitals Corporation from 1985 to 1989. Before that, I was the executive vice president and before that the senior vice president for Medical and Professional Affairs. So from '82 to '89, I was in HHC.

**RICHARD K. LIEBERMAN**

00:03:58:15

Great. So we have questions.

**WEILY LANG**

00:04:02:17 All right. So again, I'm Weily. I'm a second-year biology student at LaGuardia. I have a background in health and science and in community organizing, and I recently finished the AIDS, Science, and Society course at LaGuardia. So for our research, we looked at a bunch of memos including from David Sencer and Stanley Brezenoff around the time that you came into the HHC as president. And my question was when you came in, the DOH had a lot of issues they were focusing such as child welfare like the high infant mortality rate and the school health initiative. Did this differ from your expectations of what your priorities would be like?

**DR. JO IVEY BOUFFORD**

00:04:43:04 Well, Health and Hospitals Corporation was the sister agency to the Health Department. Commissioner Sencer was the head of the Health Department. I was actually brought in originally to HHC because of my history in primary care, and Koch was being sort of attacked by Carol Bellamy, who was the City Council president at the time, for not having a primary care agenda that the hospitals were – it was too hospital-focused.

00:05:07:22 So I came in, and my first task – Director of Medical Operations I think was the very first title when I came in – was to develop a primary care strategy for HHC. That would have been quite consistent with a concern about high infant mortality and community medicine. So when we developed that, that became a kind of signature strategic planning initiative to create the idea of HHC as the community health system for the City of New York. And over three to four years, we evolved that as our tag line.

00:05:51:04 We were looking at HMOs and other models at the time which kind of went away but trying to prepare the system for focusing more on community medicine and community health.

00:06:04:23 We also at the time were looking internationally at some of the interventions in low-income countries to deal with infant mortality especially in Bed-Stuy and Brooklyn where it was highest. Harlem was the second highest, as I recall. And UNICEF actually had some interventions for infant mortality prevention, and they were trying to transfer some of the learnings from the international arena back into the U.S. They weren't getting a lot of uptake. I think the only mayor that did that was Kurt Schmoke when he was mayor of Baltimore.

00:06:46:19 But no one else really – because the feeling – and Ed said this which was very funny. He said, "We can't use an intervention that they're using in a

low-income country in Brooklyn because what would people think? That we don't have our act together." So it was a funny conversation. But at any rate, they did design pretty much the same thing but didn't claim it as coming in from an international development perspective.

00:07:12:19 So in a way, it was more congenial to my own background than, "I'm a hospital person, and so why are they asking me to do this?" sort of thing.

**WEILY LANG**

00:07:23:06 Great. Thanks.

**DR. JO IVEY BOUFFORD**

00:07:23:22 Yeah.

**OLI ISLAM**

00:07:27:12 I'm Oli Islam. I am a second-year math and science student. I am a CPR instructor, and I wish to pursue a career in medicine and also in medical research especially HIV. That's why I was really interested in this research program. In what way would you say there were competition for financial resources between the already existing healthcare needs and the new HIV virus which was new at that time?

**DR. JO IVEY BOUFFORD**

00:07:51:07 Yeah. Really good question. A lot. And one of the issues was – and this is, I think, a really important point around – we're seeing it now in terms of Ebola, for example – is we're really good at responding to crises and not very good at long-term sustainable investment in systems. So as a consequence, when the crisis hits, things go wrong because we're not prepared.

00:08:17:00 So AIDS was a really good example about there was a lot of new money coming into AIDS at a time when there was not much money coming in to the HHC, the public hospital system– I mean there are always needs. Let's say *relative*. I think Mayor Koch was really good about HHC and investments in HHC in general, but there wasn't a lot of money going into the public system and a lot of uninsured and a lot of discussion there. So the only new money of scale was for AIDS.

00:08:46:04 So there was a lot of conversation about how do you use that money to serve the HIV/AIDS population but also build the infrastructure of the system overall. And that was what we tried to do. I think a lot of the investments in Bellevue and some in Harlem – some of the hospitals that had the highest incidence of either HIV cases or in the case of Harlem, more of the babies

and the sort of AIDS/crack babies that were at risk and then learning, through the HIV design process. HIV probably moved the system more to a comprehensive care system than anything else starting with social services, housing, supports, primary care, coordinated care management, moving into hospital.

00:09:48:07 And then in addition, at the time, we made a huge investment preparing for chronic care management of HIV patients especially some of the early data was showing people with significant incidence of dementia. And there was a fear that that was going to be a major problem. It didn't turn out to be. And I think a lot of the medications came along, and the need for the level of acute care beds or chronic care beds for HIV, happily, sort of went away. But you didn't know at the time you were planning.

00:10:23:22 So there was a big effort to make sure that whatever the investment was, it was going to be strengthening the overall system even though it would be initially focused on the HIV patients, that it would make the system better. And as I said, we learned a lot about comprehensive care and care models during that period.

**OLI ISLAM**

00:10:44:22 So you would say it was balanced between the other healthcare needs and HIV at that time?

**DR. JO IVEY BOUFFORD**

00:10:50:02 No. I would say we tried to use the HIV money to create a structure that would strengthen the system for everybody else. But it was clear that the big financial investment was for HIV.

**OLI ISLAM**

00:11:02:07 All right. Thank you very much.

**DR. JO IVEY BOUFFORD**

00:11:03:05 So there was a competition. I mean there were a lot of people who weren't happy about that, but I think it's fair to say the need was so dramatic and the political pressure so strong in New York that that was the way it was going to be. So the idea was to try to have it be a good investment in general.

**CARLOS GALINDO**

00:11:24:14 Hello. Good morning. My name is Carlos Galindo. I'm a business administration major. I'm also from LaGuardia Community College. My interest in public service is what drove me to be part of the Friends for Koch

program, so thank you for having us. So we've been able to view press conferences as well as departmental correspondence in which Mayor Koch mentions that there is no problem with the budget. However, Mr. Stanley Brezenoff mentions in a memo to you that the budget situation is tight. So how did you manage to balance these various interpretations of the budget?

**DR. JO IVEY BOUFFORD**

- 00:12:00:17 Well, everything's relative, right? One of the things that's used in public service a lot is this idea of increasing efficiency. So basically, it gets framed that way that your budget may be level or reduced, but the idea is to increase your efficiency and do the same thing for less money. So that gets positioned in that way, very commonly, and it's not to say there aren't always efficiencies that could be found in any budget anywhere. So it might be framed that way publicly even though you're, in fact, cutting your budget.
- 00:12:38:21 So what you do is to try to take that approach and to say, "Well, let's look at where we could say [break in audio] phase out things that are lower priority so we could move money around or decrease the funding for this period of time. And that's what you do. So it's very common in government and public service, I think. The budgets always go up and down in some ways.
- 00:13:07:22 And during the Koch period, because he was mayor for so long, there were periods where we had really great city funding, and most of the time, it was really good. I think towards the end of the third term, middle of the third term, it was one of those tougher periods. But I don't think we ever had to do anything really terribly dramatic during his tenure opening of Woodhull Hospital, for example, was really a strategic decision around closing two really aged facilities in the same community and opening another one. The closings weren't a budgetary move, but an efficiency, improving healthcare move from that sense – consolidating.
- 00:13:48:23 So we weren't really in a position to have to close facilities for budgetary reasons or close any major services for budgetary reasons. We were fortunate during that period. But we had to cut our budget. We argued. You always argue for money. And within an administration, you know that they have tough decisions to make between you and other people. HHC was kind of fortunate in a way because we had our own revenue stream and as a public benefit corporation were a little bit independent from the city arguments although less so than during the Bloomberg Administration. You were treated a little bit more like a city agency, but they, at some point, had to respect the fact that you had revenue sources that were coming in and that you had more authority over those.



**CARLOS GALINDO**

00:14:34:11 Thank you.

**OLIVIA FEAL**

00:14:40:17 Hi. My name is Olivia Feal. I'm in my last year at LaGuardia Community College. I hope to transfer to a four-year and major in art history. I have previous work in archives with the Rubin Museum of New York. And so the Friends of Koch program felt really natural for me because I love research, and I want to do my Ph.D. thesis on Tibetan art.

**DR. JO IVEY BOUFFORD**

00:15:08:21 All right. [Inaudible] place to be [inaudible].

**OLIVIA FEAL**

00:15:10:20 Yeah. It's a little bit different than this, but it's all right.

**DR. JO IVEY BOUFFORD**

00:15:13:12 A little. [Laughter]

**OLIVIA FEAL**

00:15:17:02 So I wanted to ask you in your Columbia Oral History in 1992, you said that the belief was that the HHC had to become a family doctor and do more in ambulatory care and primary care. How did the budget and public opinion at the time affect your beliefs on ambulatory care, and did you feel that there was a conflict with what you wanted with this versus what was being done?

**DR. JO IVEY BOUFFORD**

00:15:51:13 Well, I think we were trying – this is one of the big conundrums of healthcare financing, and it still is, actually, is that we tend to fund acute care hospitals in the United States, and we're a very hospital-oriented, very specialty-oriented country in terms of our investments. And if you look at our international standing on health result, it's very poor because we're over invested in acute healthcare. So there's never been a level playing field on funding primary care in this country, so it's not unique to New York. It's not unique to HHC.

00:16:27:11 So I think for a system, we were, in a sense, kind of bucking the tide in some ways and reconfiguring the system to do what we felt was the right thing even though the reimbursement system was at the time and continues to be more rewarding on the acute care hospital side. So we did have a huge percentage of NYC's hospital-based ambulatory care, and New York City is very focused on hospital-based ambulatory care relative to other cities.

00:16:57:09           So it was in our financial and efficiency interest to get people out of the emergency room, out of the hospital-based system and have them in a primary care community-based clinic, primary care clinic. So we did convert Cumberland Hospital and Greenpoint to some degree, when they were closed, into a full-service – in the case of Cumberland – ambulatory care center with the idea that people could be managed better in community-based centers and then triage to be referred to the hospital for specialty care.

00:17:31:06           So we were doing all of that as were people in some other systems even in the face of the fact that the reimbursement system didn't necessarily reward it. So that is still the case in New York. And actually, two days ago, New York was advised that they've gotten the sort of last piece of the waiver funding for something called the State Health Improvement Plan which will be \$100 million investment in advanced primary care to try to beef up primary care in the State of New York. That is compared to a \$10 billion investment in the hospital side, reconfiguring hospitals in New York. So we're still in that place.

00:18:16:13           I think the reconfiguration plan envisions downsizing hospitals, right-sizing hospitals, and focusing much more on ambulatory care and prevention. But the system structure is still pretty much the same. So when you're focusing on the family doctor for New York City or primary care, you're still running against the tide on the reimbursement side all of these many years later.

**OLIVIA FEAL**

00:18:43:12           Sorry, I just wanted to ask a follow-up.

**DR. JO IVEY BOUFFORD**

00:18:45:13           Yeah, sure.

**OLIVIA FEAL**

00:18:47:08           So you did mention that you were kind of brought into this position because of your background on this type of primary care and stuff. Did you feel like there were improvements being made after you were brought in from what was done originally? And also, do you feel like maybe they helped give you more funding after you were brought in for this type of care?

**DR. JO IVEY BOUFFORD**

00:19:18:17           Yeah. Well, we had support. We started a unit, a professional unit, Division of Ambulatory Care, and brought in leadership there. In fact, LaRay Brown, who's now the senior vice president for Strategy and Community Relations at

HHC, was brought in before she got her doctorate. She was like a young Turk coming in to work on the primary care and community relations stuff.

00:19:39:13 So we had a really good group of staff, and we did develop an ambulatory care initiative. We got support for creating a director of ambulatory care in all of our hospitals which forced the various specialty areas to integrate under someone who was really looking at the model and the design for the ambulatory care services rather than having medicine and pediatrics and OB/GYN, and surgery doing whatever they needed to do for their healthcare and training purposes. They had to really bring together a concept of more continuity of care and more responsibility and patient-oriented design.

00:20:20:14 I think since then, we were able to get some new health centers funding in a capital budget and our attention to IT systems especially when we had the capability of designing them from the beginning at Woodhull with Cumberland and a couple of other health centers there, and we were able to connect the IT systems between the Community Health Center and the hospitals. So there were desks at Woodhull for patients coming in from Greenpoint or Cumberland, so they didn't have to figure out how to navigate the system. They had their appointments; they had their records ready.

00:20:53:12 So that happened in a few places. There was a set of networks around Harlem Hospital as well. And like everything else, you have the infrastructure there, and then things go off the boil when you leave. That's one of the issues of public service. Priorities change, and so you try to kind of establish a beachhead and get people's mindsets shifted while on your watch, as they say. And then in some instances, there will be a sustainability of that infrastructure if you can get it far enough. I think we set the mindset of primary care and ambulatory care into the system.

00:21:31:14 It's been interesting now reentering as a board member that some of that is forgotten, and some of it is remembered, and some of it – it will come back. But I think HHC is now quite well positioned relative to other hospital systems in terms of the ambulatory care. Whether it's gotten the sustained emphasis over time, I think is a little less clear. But it's there, and it will be helpful. Yeah.

**OLIVIA FEAL**

00:21:58:20 Thank you.

[Adjustments to camera and microphones]

**DR. JO IVEY BOUFFORD**

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00:22:23:09 This is like a high-end thing – two camera [inaudible]. [Laughter]

**UNKNOWN FEMALE**

00:22:27:01 We're fancy.

**DR. JO IVEY BOUFFORD**

00:22:27:21 You are. It's true.

**RICHARD K. LIEBERMAN**

00:22:31:09 We're going on Broadway with this.

**DR. JO IVEY BOUFFORD**

00:22:32:04 Well, I saw these people on TV, and they're like, "Um huh," [makes face] like this because they only had one camera. [Laughter]

**RENELLE PEREIRA**

00:22:39:12 So hello. My name is Renelle Pereira. I'm a liberal arts major at LaGuardia Community College. The reason I took up this internship with Friends of Koch was because I've been in the country for a year now. I've moved from India, and I don't know much about the city, the history of America, the history of New York. So desire to really get into that was why I volunteered to do this internship.

00:23:12:05 So my question is you mentioned in the 1992 Columbia University Oral History that Carol Bellamy – and you just said it as well – Carol Bellamy was "agitated about the failure to deliver primary care in the city." She also mentions a lack of proactive educational initiatives by the administration and their response to the AIDS crisis. So how did the HHC reach out to the inner city?

**DR. JO IVEY BOUFFORD**

00:23:44:12 Well, I've talked a little bit about the primary care side of it in terms of – I mean our ambulatory care initiative, our primary care initiative wasn't only for HIV at the same. It presaged a lot of the focus on HIV. It's an interesting question. The HHC hospitals have community advisory boards which are quite active whereas voluntary hospitals have boards of trustees who are often gay men or national leaders. HHC really has people from the community. So there's a lot of give and take, and depending on the hospital or the clinic, there's going to be more or less direct community engagement. It always depends on the activism level.

00:24:25:10 HHC central a Community Relations office, and then there was a central sort of community health advisory board where someone from each of the

facilities would come in on a regular basis and meet with the officers. So I think it was more community advisory groups centered around facilities and then bringing them in to have those conversations whereas a lot of the proactive health education would have come out of the Health Department especially on something like HIV/AIDS because that's their specialty as public health professionals and epidemiologists. Ours would have been more clinically based. The patient would have to have entered the formal healthcare system, probably, to take advantage of what we might have to offer rather than doing a lot of outreach.

**RENELLE PEREIRA**

00:25:11:16 Can you tell us a little more about the Community Health Project of 1985? What were your liaisons in the community at the time?

**DR. JO IVEY BOUFFORD**

00:25:24:23 Well, I think most of this was restructuring the [inaudible] [break in audio] system. Again, the community advisory groups of the different facilities would probably – it would have been presented to them; it would have been discussed. I don't think they were involved in the actual – I wouldn't have, from the Central Office, involved them in the design. Some of my colleagues at the hospitals or the facilities might have involved their community advisor groups. But it was more of an organizational structural change.

**RENELLE PEREIRA**

00:25:53:14 Okay. Thank you.

**DR. JO IVEY BOUFFORD**

00:25:59:12 And then marketing afterwards [inaudible].

**MAHEEM WELCOME**

00:26:03:14 Good morning. I just want to start off by thanking you for your time. My name's Maheem Welcome. I'm a history major at LaGuardia Community College. I'm specifically interested in New York City history as well as its development which made the Friends of Koch seem like a natural progression for me. I'm interested in going on and becoming an urban planner so that I can help create sustainable communities within New York City.

**DR. JO IVEY BOUFFORD**

00:26:28:17 Great. And health. Promote health. Urban planning is really getting into health big time. That's good.

**MAHEEM WELCOME**

00:26:34:06 Um huh. Particular for, in my case, [inaudible] make sure that the community is developed in ways so that it can be protected so a lot of health problems that we'll probably have or will soon appear would be mold and that sort of thing.

**DR. JO IVEY BOUFFORD**

00:26:51:14 Yeah, post-Sandy is a big deal. Yeah, big deal and being near the water, yeah.

**MAHEEM WELCOME**

00:26:55:14 Yeah. My question is do you know of or were you a part of any meetings regarding the shift of the DOH and the Koch Administration from focusing solely on gay men to incorporating drug users in regards to the AIDS issue?

**DR. JO IVEY BOUFFORD**

00:27:16:01 Well, I think as the data began to be available and the epidemiology became available, I don't think there was like, "We're only focusing on this population and not the other." It just all of a sudden, it was more visible. You had to add issues like more explicit substance abuse programs. And interestingly, in the HHC, some people in the gay community might have complained that there was more focus on substance abuse because they're the patients that come to HHC. A lot of the gay men, especially, would not necessarily have come to HHC as the first healthcare choice. I think Bellevue was where a lot of investment went because it was in one of those communities that was able to pick up across the communities.

00:28:08:19 But Harlem, Bed-Stuy, Kings County – we would have tended to get the people of color or people with substance abuse problems, women who were involved in relationships where they might have been infected. They would have been our patients in some ways more than the gay community who probably would have been more likely at St. Vincent's in some of the voluntary hospitals in the Village.

00:28:30:03 So it wasn't so much a distinction for us. I think it was just the reality of the patients we were taking care of led to having to put the service pieces together. So I think in some ways, other than Bellevue, it probably would have been the opposite in terms of the lead part of it.

**EDEMIR CASTANO**

00:28:57:15 So my name is Edemir Castano, and I'm a liberal arts, math and science major. It's my last year, and I'll be transferring, and I want to devote my time to getting an undergraduate in philosophy and a minor in public health as well.

**DR. JO IVEY BOUFFORD**

00:29:13:18 All right.

**EDEMIR CASTANO**

00:29:14:14 So my question for you – you’ve kind of already answered it – was why the HHC hospitals were focused on drug users whereas the – but you answered that. So the second part of the question is why this was a good thing for HHC to be focused – because in your Oral History, you state that it was kind of a good thing.

**DR. JO IVEY BOUFFORD**

00:29:36:13 Oh, the HIV/AIDS?

**EDEMIR CASTANO**

00:29:37:12 Yeah, exactly. So why was that a good thing that there were drug users going to HHC as opposed to gay men?

**DR. JO IVEY BOUFFORD**

00:29:43:09 Oh, yeah. Well, I didn’t mean that distinction. I meant the HIV epidemic, I think.

**EDEMIR CASTANO**

00:29:47:05 Oh.

**DR. JO IVEY BOUFFORD**

00:29:47:11 And preparing the health system for HIV was a good thing for HHC. Part of it I mentioned before; there was an influx of funding which we tried to use to build infrastructure that was good for all patients. But it also forced attention to coordination of care and comprehensive care. It’s very much the same conversation that’s going on now in healthcare reform is how do people have a primary care physician of record who helps coordinate their care and you manage the care of individuals as they move through the system in terms of first line versus subspecialty or long-term care.

00:30:23:02 So the HIV/AIDS crisis really – and people who were really good and smart about the system design really got early on you had to have both Health and Social Services; you had the issue of stigma where people were losing their homes and their ability to work, so their whole set of benefits had to be created that were there. And then they needed care in hospital, back out, support systems at home. All of those pieces were so obvious for people with HIV/AIDS which, in fact, are the same pieces that people with chronic disease need now – I mean a little bit less hospital than at the time.

00:31:03:13           So it forced a design of a healthcare system that was – everybody knew that it was the way we should be offering services to all patients, but we didn't have the resources or the structure to do that. So that's what I meant about it being good for the need to attend to and design a comprehensive care approach for HIV/AIDS patients was a good thing for the system and for healthcare as a whole.

00:31:31:02           It's really interesting to talk to a lot of people who are healthcare professionals who were around during the HIV/AIDS epidemic. Many of them will say that the first time there was really a real serious look at integration of Health and Social Services and comprehensive approaches to care was with the HIV/AIDS epidemic. And now we're trying to do it for everybody. But we should have been doing it for everybody all along.

**EDEMIR CASTANO**

00:31:54:07           And I had another question for you. I wanted to know – so you spoke earlier about the community advisory groups as part of the HHC. How does one become nominated or become a member of this advisor group?

**DR. JO IVEY BOUFFORD**

00:32:07:05           Well, it's an interesting question. There's sort of a structure, as I understand it, and some of them are nominated by the local executive director and with the approval of the Central Office of HHC. And some of them are actually – I don't know if they're formally nominated but suggested by the borough presidents or local council persons. The HHC's board structure is prescribed legally. There's a certain number of nominees by the mayor and others by the borough presidents and others are ex-officio agency heads related to health and human services. I probably knew at some point about the formal structure for the advisory boards of the HHC facilities. But my guess is that there was some combination of nominations by the borough presidents or local council persons and HHC formally.

**EDEMIR CASTANO**

00:32:58:00           Thank you.

**DR. JO IVEY BOUFFORD**

00:32:58:16           So they would have been, ideally, community activists but also people who were involved in networks of politicians and others.

**RICHARD K. LIEBERMAN**

00:33:09:01           So now is our chance to just open with discussion. And everybody's asked their formal questions and their follow-ups and taken notes. So I'm going to



start. Jo, you know that Koch was always under attack on this topic of AIDS. He was attacked for [inaudible] gay men. He wasn't doing enough. And you were in the middle of that discussion. What was it like at the meetings when you were right in the back rooms there and responding to this public outcry? And I hear the sigh.

**DR. JO IVEY BOUFFORD**

00:33:43:16 Yeah. It's really hard. I'm not the greatest historian type in terms of – I mean the questions you're asking are really interesting because it makes you remember things. I don't have one of these kind of encyclopedic memories. But I do feel very strongly about a few things. First of all, I came to HHC in '82, '83, and all the people who write in the retrospectoscope notwithstanding because I had a lot of good physician friends who were also gay who were treating gay men who they had no clue what was going on in '82, '83. I mean there may be scientists at NIH who knew that there was a retrovirus or something else. I don't think so.

00:34:28:23 But a lot of people – and they were meeting at the Health Department every week. These are largely clinicians in the Village who were taking care of gay men. And they were really good. They were trying to understand what was going on. They knew there was an autoimmune disease. A lot of people had come from holiday in Haiti. You may remember that. And there were a lot of guys who had gone down there on vacation. And so that was a clump of people, and you could get a bunch of internists around the table saying, "Yeah, I have a patient who did that." So that was one thing. It was just, "I've been to Africa. I've done this; I've done that."

00:35:04:01 So people didn't really know. And so when I read the guy who wrote the book – I can't remember the name of the book – that was largely focused in California and the San Francisco response, [Inaudible] –

**RICHARD K. LIEBERMAN**

00:35:16:09 [Randy Schiltz?](#)

**DR. JO IVEY BOUFFORD**

00:35:17:05 Randy Schiltz's book, yeah. He didn't spend a lot of time in New York, and there were a couple of chapters in New York. He kind of blew it off in a way, and I think wasn't really fair to anybody that was there. But I can tell you that – and I say this a lot, and I really feel very strongly about it – David Sencer, who had been maligned as the person who blew it on swine flu because he overreacted and had to resign – if it hadn't been for David Sencer, this country would not have ended up doing what it did for HIV/AIDS because he essentially, under Reagan – the MMWR for CDC was being

censored. They were not able to publish what was going on in the HIV epidemic for a long time. And a lot of whatever was going on that emerged was because David – and this is my view, and other people may have different views – but David was really back-channeling information to and from CDC during that period at great personal risk and professional risk.

00:36:22:05

And so whatever we did was really – and [Steve Joseph](#) was there at that point, moved on after David left – was very evidence-based. And I think that when the evidence arose and the data was there, I think Ed was very good, generally, on this. Now whether – I mean in New York, you can have five people arguing over lightbulbs. So whether this one got more than that one or whatever, I never had a sense that there was any discriminatory interest. You asked the question sort of in that way, “Why didn’t he do this?” That wasn’t so much an issue for HHC and city provided benefit services. It was really an issue of, “Where’s the [inaudible], our patients?” In some ways, I don’t know that gay men would have gone to Bellevue if there hadn’t been a special unit there and a special program there or similarly to Lincoln if they were in the inner city, they might have been our patients. But whoever the patients were who had the infection, that was the way it was designed around and they were treated.

00:37:24:08

So I always thought that was quite unfair although thank goodness people were as active and visible and continuing relentlessly to advocate as they were because you had to be to get the issue on the table. But I think New York was – and I think that whole complex of the mayor, Dave Sencer, later Steve Joseph – I think they were pretty good, considering the evolving state of knowledge. And there were a lot of union issues and public confusion: could you catch AIDS from touching a doorknob. All that stuff was going on, and it wasn’t particularly unusual. It was sort of like, “Where does Ebola come from?” You get it – I mean look at what’s going on now with Ebola. And the data on Ebola is just overwhelmingly clear. But you see what’s going on in the community, so you’re living another epidemic where people, evidence notwithstanding, have the reactions they have. And you have to deal with it.

**RENELLE PEREIRA**

00:38:32:08

So you mentioned that David Sencer was back-channeling information from the CDC at that time?

**DR. JO IVEY BOUFFORD**

00:38:37:07

That was my impression.

**RENELLE PEREIRA**

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00:38:40:11 In the memos, I was very surprised at how much he knew and how much Mayor Koch knew as early as '82, '83.

**DR. JO IVEY BOUFFORD**

00:38:44:12 Oh, yeah.

**RENELLE PEREIRA**

00:38:47:19 I notice also that in later memos, David Sencer was really against using the diagnostic, the HIV tests that were available at the time because I think that was the year that they came out. He said they were only 85 percent effective in positively testing for HIV. Do you know why he was so against having those tests [inaudible]?

**DR. JO IVEY BOUFFORD**

00:39:11:00 You're beyond my – this is not something – I'm not a public health professional, and I don't know anything about that. I wouldn't want to say anything about it because it would be uninformed.

**RENELLE PEREIRA**

00:39:20:17 Okay. Thanks.

**DR. JO IVEY BOUFFORD**

00:39:22:15 That would have been Health Department stuff. [Laughs]

**CARLOS GALINDO**

00:39:27:09 I have a question. In hindsight – and of course, hindsight is 20/20 – it seems much easier to say something now than it was back then. But looking back, do you think there's something the administration could have done differently or should have done differently that might have better handled the crisis at the time?

**DR. JO IVEY BOUFFORD**

00:39:49:08 The answer to that kind of question is always, "Yes." You could always have done more or done something differently. I think we tried – and I did not personally – and again, I was not in the Health Department. I don't know that conversation. As far as HHC is concerned, I did not experience any reluctance to make investments or to take the steps that had to be taken to create the services that were needed to take care of HIV patients.

00:40:18:06 And there were issues. As always in New York, the health professionals with the highest level of understanding were unbelievable – the nurses, the doctors. It's just in the system. And a lot of union organizers were, I think,

genuinely concerned and anxious on behalf of their workers. Some of them were using it for other purposes, as always. But there were a lot of issues with laundry workers, with lab workers, with other things. There was a lot of work that had to be done. I think we probably could have done a lot more – educating people and preparing them and stuff. But you're not necessarily on the front lines where that happens. You're getting the union organizers that are saying, "We're going to go on strike, and our folks aren't going to do this," and there might be a [needle](#) and a bed linen, and they're all reasonable things.

00:41:04:06 So that area probably – there might have been relatively more investments in those areas or those issues. But I think we, within the constraints of finances, moved as quickly as people could and as the evidence warranted. So I didn't experience any kind of holding back or foot-dragging in relation to what we needed to do. If you had more money, you could always do more.

**OLIVIA FEAL**

00:41:31:09 I have a question. I was just wondering – you spoke a little bit just now about the education, the role of education. And I know that there was – or I don't know, but I'm guessing that there was a fear from many hospital workers in the Public Health Department and elsewhere. And I want to know a little bit about how the HHC went about educating their workers just in more detail about how to maybe deal with AIDS patients or drug abuser patients with HIV – that sort of thing – to make them feel more comfortable or not.

**DR. JO IVEY BOUFFORD**

00:42:11:21 Well, there would have been. I think there would have been training programs designed and funded for nurses, nurse educators that are always on staff, and they were specifically given the training information about HIV, and they then, in turn, would train the nursing cadres at the hospital – similarly, physician leadership groups because it's a very heavily-resident – a lot of residents in public hospitals. All of them would have been trained by the doctors.

00:42:37:22 And then there were the lab techs. Each of the professional divisions or the operational units would have had special training. And there are different techniques sort of what you're seeing with Ebola. People are being trained and prepared, and that was the same thing that happens because you do that in hospitals when you have different kinds of patients that raise different kinds of issues. So gowning, gloving, disposal of sharps, reporting of punctures, and whether you give people AZT early on to try to – so all of that was being done. It's just the normal – if you know you have a group of

patients that need special precautions – like if you have a TB patient, they go into a room where you have reverse filtering of the air. It's just the way hospitals work.

00:43:24:23 And I think relatively speaking, there was probably more urgency, more investment put in in a crisis situation, and it had to be sustained. It wasn't something you could do once. You had to keep doing it. So there's a big bump in the training budget and bringing people in from Atlanta and other places that had experience.

**OLIVIA FEAL**

00:43:45:13 Thank you.

**CARLOS GALINDO**

00:43:47:14 I have a question. You briefly mentioned about marketing, the marketing aspect. So at the time, all the misconceptions and fear about HIV and AIDS – so how did the HHC go about marketing care for the patients?

**DR. JO IVEY BOUFFORD**

00:44:03:06 Well, I think probably most of the focus of HHC would have been, as I said, on our staff and on our education of patients who would be using our facilities. I think the Health Department would probably have been more involved in the community outreach. You see that now with Ebola. There are people in the community all the time having community meetings, advising people, et cetera.

00:44:28:08 I think it's fair to say we've gotten much more sophisticated over the last 20 or 30 years about how to do community outreach and community education and getting community influentials to help bring the right people to the table. It's a much more sophisticated process than it was at the time. But I think the Health Department would have done the bulk of that, and HHC would have been focused more on our own staff and the patients that we took care of which is a lot of patients.

[Camera adjustments]

**RICHARD K. LIEBERMAN**

00:45:08:15 It's interesting, and you think of Koch as, if nothing else, a huge personality in terms of press and his ability to convey the message. But in this area, he couldn't do it.

**DR. JO IVEY BOUFFORD**

00:45:23:00 Well, that may have been a legitimate criticism. I don't know. I hadn't thought about it quite in the way you're just framing it – that he, in the bully pulpit, should have used it more for this. Yeah, I don't know. It's very interesting because when you think about any number of emergencies that come up with different infectious diseases and, "Do you front your public health officials or let the electeds do it?" And I think those are choices that you make in some ways.

00:46:01:11 And I think in some instances, on things like healthcare reform or – I'm trying to think if it was – yeah, HIV or SARS, you see it at the federal level, and you see it locally as elected officials make decisions about who's going to talk to the press about a particular issue. And I tend to think that it's reasonable to put the public health professionals out there on these issues. I would question – and I've said this; this is not dish or anything, but I think in terms of selling the healthcare reform in the United States, this administration made a mistake by having political and budgetary leadership, Tim Geithner and David Axelrod and stuff, on the Sunday morning talk shows selling the healthcare reform rather than using the secretary of HHS who was not only a commissioner of insurance but a governor who knew this program inside out or people at CDC or others.

00:47:11:08 And then you get an outbreak in the Bush "2," I guess it was, and they didn't put Dave Satcher out; they didn't put Tony Fouchi out. And yet now, with Ebola, Obama, I think rightfully, is leading with his experts. And I think that's a choice you make. You could criticize him for saying he "didn't do it." And I don't know, but I think those are interesting choices one makes in public administration. And there may be a point where you have the pulpit, and you have to do it, and you could say Ed was – you're right; he was larger than life, and people might have listened in a different way had he been more proactive about it. I don't know what was in his head then because I wasn't part of those conversations in terms of those decisions. When you're running a hospital system, it's not the Health Department.

**RICHARD K. LIEBERMAN**

00:48:07:20 It is interesting that you're saying that because we've looked at the press conferences, and he does push you and Sencer forward. He backs away.

**DR. JO IVEY BOUFFORD**

00:48:15:13 Yeah, yeah. Well, I'm just saying I think that's a choice. But you were saying he was being criticized.

**RICHARD K. LIEBERMAN**

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00:48:19:02        Yeah. But you're saying that maybe he should have taken over the press conferences.

**DR. JO IVEY BOUFFORD**

00:48:23:14        No, I said he could have, perhaps. But I'm saying those are choices you make. I don't think it should be seen as dodging the issue. I think it's a choice elected officials make about who are they going to have to lead on something where they may start getting questions. You just asked me a question about 85 percent effectiveness or whatever. What if that was the second question, and then he can't answer it, and then he looks like an idiot? I think those are legitimate. You don't do a press conference as an elected official unless you've mastered the brief and you have a sense of what the questions are going to be.

00:49:01:12        One of the examples I remember a lot was being out there on the ambulance-purchasing issue because we were being taken to the cleaners. [Inaudible] says it didn't work and all that sort of stuff. And it was one of the few times he said to me, "This is yours." [Laughs] Usually, he was pretty good about stuff. But it was very technical because the first question is, "Why did you pick this company?" And then after that, it's, "Well, the axels this, and the width is, blah, blah." Do you know what I mean? What is he going to do? And then you look like you don't know what you're talking about, and then the public gets confused.

**RICHARD K. LIEBERMAN**

00:49:34:03        Got it. Got it.

**DR. JO IVEY BOUFFORD**

00:49:35:00        And those choices are made all the time. I think it was really interesting the difference between – in this last round on Ebola with the mayor and the governor. So the mayor, the governor, and Bassett are sitting at the table, and Ram Raju were sitting at the table. They do a really nice job. The mayor goes with his professionals. The governor doesn't say anything. And the next day, the governor reverses himself, and his commissioner didn't say a word. So that was clearly a political decision about how to handle it. There were a lot of people, I'm sure, that felt like De Blasio wasn't aggressive enough, yada, yada, yada. In this case, he went with the evidence base from his science advisors, from his Public Health leadership.

**EDEMIR CASTANO**

00:50:32:00        So if you had to give advice to a new president of HHC especially with the Ebola [inaudible] happening, what advice would you give them?

**DR. JO IVEY BOUFFORD**

00:50:42:14 Well, they're doing it. I'm on the board, so I see what they're doing. [Laughs] HHC really is the first line, has been the first line. Bellevue is the first place where there were **beds** available [break in audio] to take care of it. There are a couple of other voluntaries that have gotten huge investments, I must say, in order to develop their bed capabilities, and now it's part of a national system which hopefully will be helpful and hopefully not too many future crises like that.

00:51:08:05 But HHC stepped up. You do what you have to do. I mean they stepped up to the plate and did it. And so they did it very well, and that's what I would have said. The thing about government, government is the first line. You have the ultimate responsibility for assuring the health of the public, and you don't argue about that. You just do it. And I've never seen anybody in those front-line situations say, "I don't really want to do that." [Inaudible] for Presbyterian or Mount Sinai. It's not an option.

00:51:36:13 So I think that's one of the exciting things about being in government, and one of the really rewarding things about it is that ultimately, the buck stops there in terms of public health. Government has that responsibility to assure the conditions in which people can be as healthy as they can be. And that doesn't mean doing it alone, and sometimes it doesn't mean doing it at all. But that word, *assurance*, is a really important word. You've got to make sure the pieces are in place and that the partners you have to have working with you are working with you. So I think it's unfair to say, "You have to do it all yourself." But you do have to have it orchestrated, and you have to get those partners to the table, and sometimes they don't want to come.

00:52:19:16 But I think they did it very well, and it was a very normal response. It's not an accident that when something happens to the president in New York, they go to Bellevue. They don't go anywhere else because they're ready. They have to be ready for this stuff. So I think that's the answer. They did it well, and they did it because that was the logical place to go. I'm sure the phone was picked up and they called the mayor, and that's it. They're ready. They knew it was going to happen in New York. It was inevitable because it's a port; it's a **past** [inaudible] city, and they had to get ready.

**EDEMIR CASTANO**

00:52:57:13 Thank you.

**OLI ISLAM**

00:53:01:14 Yes.



**RICHARD K. LIEBERMAN**

00:53:01:21 One more? Last question.

**OLI ISLAM**

00:53:07:11 I think you kind of hinted that we could have been a little more proactive. And I think especially at that time, there was this notion that San Francisco was being a lot more proactive than we were. Would you agree with that? And if they were, why do you think we weren't as proactive as San Francisco?

**DR. JO IVEY BOUFFORD**

00:53:24:08 I don't know. It's hard to know. All I know is what I said. Because I'm not a public health person, I wasn't following the evolution of thinking about the disease as it was. We were dealing with the service, and we're just a little bit further along the continuum. Again, I don't know if it's tied up in the way it was written up or whether people – all I can tell you is my experience was that there was still – I mean our focus was really caring for sick people and etiology.

00:53:59:17 So I think in terms of outreach and prevention and other areas, I'm not necessarily the right person to ask that question to make a comparative judgment. I think we were ready and working to do what we had to do and did a good response. I think there may have been an issue. It's an interesting question. You raised it – is whether the sort of gay lobby was stronger in San Francisco and there was less of a diffusion of the disease. I mean to the degree that our patients or some of the early patients would have been drug users, the public is not the most sympathetic, necessarily – the "deserving" whatever. And so it may not have gotten the political attention here from the gay community that was really such a turning point in so many communities. I think it's a much more homogeneous community in San Francisco. So it's an interesting question to think about. I don't really know the answer.

**OLI ISLAM**

00:54:56:16 Thank you.

**RICHARD K. LIEBERMAN**

00:54:58:01 Thank you very much.

**DR. JO IVEY BOUFFORD**

00:54:58:20 You're very welcome. I enjoyed it. Very nice to meet you all.

["Thank you" from group members and applause]

**RICHARD K. LIEBERMAN**

00:55:06:11 Okay. Now the cameras are off, we can get to the real questions.  
[Laughter] Watch your step on that wire.

**DR. JO IVEY BOUFFORD**

00:55:11:11 Yeah. There's a hole here. I noticed that. I wasn't worried so much about  
the wire as the –

**RICHARD K. LIEBERMAN**

00:55:14:14 Oh, there's a hole there, too?

**DR. JO IVEY BOUFFORD**

00:55:15:20 Well, for the plug-ins, I guess.

**UNIDENTIFIED FEMALE**

00:55:18:18 So this is a donor form for the Archives just saying that we're going to  
preserve the [inaudible].

**DR. JO IVEY BOUFFORD**

00:55:22:07 Oh, okay. Sure. Okay, thanks.

**[End of audio]**

**Duration: 56 minutes**