CITY COUNCIL
CITY OF NEW YORK

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TRANSCRIPT OF THE MINUTES

Of the

COMMITTEE ON HEALTH JOINTLY WITH COMMITTEE ON HOSPITALS

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November 26, 2018
Start: 1:13 p.m.
Recess: 3:50 p.m.

HELD AT: Committee Room – City Hall

B E F O R E: MARK LEVINE
Chairperson

CARLINA RIVERA
Chairperson

COUNCIL MEMBERS: Alicka Ampry-Samuel
Inez D. Barron
Mathieu Eugene
Keith Powers
Diana Ayala
Mathieu Eugene
Alan N. Maisel
Francisco P. Moya
Antonio Reynoso

A P P E A R A N C E S (CONTINUED)

Matilde Roman, Chief Diversity and Inclusion Officer, New York City Health and Hospitals

Dr. Demetri Daskalakis, Deputy Commissioner, Division of Disease Control, NYC City Department of Health and Mental Hygiene

Ashe McGovern, Director of NYC Unit Project & Senior LGBTQ Policy Advisor, Mayor's Office

Barbara Warren, Director for Lesbian, Gay, Bisexual and Transgender Programs and Polices
Office for Diversity and Inclusion, Mount Sinai Health System & Assistant Professor of Medical Education at Mount Sinai's Icahn School of Medicine

Nathan Levitt, Nurse Practitioner Coordinator in our Transgender Surgery Program, NYU Langone Health

Kimberly Smith, Callen-Lorde Community Health Center

Brianna Silverberg, Intern, Policy Department of GMH and Trans Woman

Cecilia Gentile, Manager of Policy and Public Affairs, GMHC Gay Men's Health Crisis & Founding Member of Equity Coalition

Dr. Freddy Molano, Vice President for Infectious Diseases and Education Programs, Community Healthcare Network

Chelsea Goldinger, Government Relations Manager
Lesbian, Gay, Bisexual, and Transgender Community
Center

Vanessa Victoria Crespo, Client Advocacy Specialist
and Counselor, New York City Anti-Violence Project

Kiara St. James, Executive Director and Founder
New York Transgender Advocacy Group, NYTAG

Tanya Asapansa Johnson Walker, Co-Founder
New York Transgender Advocacy Group, NYTAG

Noel Lewis, Intern and Senior Staff Attorney at
Transgender Legal Defense Education Fund and
Executive Director of Transgender Legal

Sasha Alexander, Director of Membership
Sylvia Rivera Law Project

Carrie Davis, Healthcare Consultant and Trainer
New York State Commission on Human Rights

2 [sound check] [pause] [gavel]
3 CHAIRPERSON LEVINE: Good morning
4 everyone. Welcome. Good afternoon. Thank you. A
5 little disoriented after the long weekend. I'm Mark
6 Levine, Chair of the City Council's Health Committee.
7 Pleased to be co-chairing this hearing with Chair
8 Carlina Rivera, and excited that we have so many
9 people who are here today to speak and testify on
10 this important issue. I know many of you and thank
11 you for fighting for this very important community.
12 As you know, our hearing today is focused on quality
13 and accessibility of healthcare for individuals who
14 are transgender and gender non-conforming or TGNC.
15 Last week on November 20th we observed Transgender
16 Day of Remembrance, a day when we memorialize and
17 honor the memories of those who have been murdered
18 simply for being who they are. Americans who are
19 transgender and gender non-conforming face
20 extraordinary discrimination, violence and
21 marginalization. Since the beginning of 2018 at
22 least 22 transgender people have been murdered across
23 the United States. The TGNC community faces unique
24 healthcare needs relating both to physical and mental
25 health, and they are far more likely to experience

2 poor physical and mental health outcomes. When
3 surveyed by the National Center for Transgender
4 Equality, TGNC respondents rated their health as poor
5 or fair at higher rate than the U.S. general
6 population, and reported experiencing serious
7 psychological distress at a rate almost eight times
8 that of the U.S. population as a whole. Individuals
9 who are TGNC face physical and psychological health
10 risks related to societal pressure to "de-transition"
11 outdated and fraudulent methodologies like forced
12 conversion therapy and external physical and sexual
13 violence toward their community. TGNC individuals
14 are also more likely to experience mental health
15 risks including, but not limited to higher rates of
16 suicide attempts and substance abuse. Additionally,
17 TGNC individuals experience HIV and AIDS at far
18 higher rates than the general population.
19 Affordable, accessible and comprehensive healthcare
20 is crucial for the survival and health of the TGNC
21 community. While New York State ensures that health
22 insurance purchased through the healthcare
23 marketplace, Medicaid, Medicare, and many employee
24 sponsored plans, cannot legally discriminate against
25 transgender individuals, TGNC individuals still

2 experience widespread discrimination and
3 misunderstanding from healthcare providers and as a
4 result, too often lack safe access to primary and
5 preventative healthcare. Today's hearing will give
6 the committees an opportunity to hear from the
7 Administration and from advocates in the TGNC
8 community on the work they are doing to ensure safe,
9 accessible healthcare for our fellow TGNC New
10 Yorkers. We look forward to hearing the ways in
11 which we can better support the health needs of this
12 community. I want to acknowledge that we've been
13 joined by committee members Diana Ayala, Antonio
14 Reynoso, Francisco Moya, and I'm now going to pass it
15 off to Co-Chair Carlina Rivera.
16 CHAIRPERSON RIVERA: Thank you so much.
17 Good afternoon everyone. I am Council Member Carlina
18 Rivera, Chair of the New York City Council Committee
19 on Hospitals, and I want to first start off by
20 thanking my colleague Council Member Mark Levine who
21 is the Chair of the Committee on Health for jointly
22 chairing this hearing with me this afternoon. Since
23 President Trump took office his Administration has
24 worked to limit the rights of Americans who are TGNC
25 including students, incarcerated individuals, and

2 working folks. As we speak, the Trump Administration
3 is considering redefining gender as a biological
4 condition determined by genitalia at birth, a move
5 that would roll back many protections of the TGNC
6 community under Federal Civil Rights Law. As the
7 Federal Administration continues to attack the rights
8 of those who are TGNC, it is critical for the city to
9 support this community. Accessing healthcare is a
10 critical issue for the TGNC community. According to
11 the 2015 National Transgender Discrimination Survey,
12 which surveyed 27,715 transgender individuals, one-
13 third of respondents who saw a healthcare provider
14 during the year prior to completing the survey, had
15 at least on negative experience related to being
16 transgender, such as being verbally harassed,
17 physically or sexually assaulted or refused treatment
18 because of their gender identify. As a result, many
19 TGNC individuals either avoid healthcare services,
20 have difficulty finding providers that adequately
21 understand their social and health concerns or may
22 avoid discussing gender with their providers. Today,
23 we’ll be hearing testimony form the Administration
24 and TGNC advocates regarding the discrimination and
25 challenges New Yorkers who are TGNC experience in

2 accessing healthcare services and explore the
3 resources the offers to help TGNC New Yorkers get the
4 care they need in a welcoming and safe environment.
5 The committees also look forward to examining whether
6 there is any additional assistance the city can
7 provide to better support TGNC New Yorkers. New York
8 City will continue to protect the rights of those who
9 are TGNC and we will continue to validate their
10 experiences and needs even if the federal government
11 refuses to. Thank you.
12 CHAIRPERSON LEVINE: Thank you, Chair
13 Rivera, and now we're going to invite the
14 Administration to offer its testimony. Good morning,
15 Deputy Commissioner—Commissioners.
16 Good afternoon
17 CHAIRPERSON LEVINE: [interposing] Oh,
18 forgive me. We have to administer a little procedural
19 matter the affirmation. I'm ask Committee Counsel
20 Jose Emanuel her to please.
21 JOSE EMANUEL: Would you raise your right
22 hands, please. Do you affirm to tell the truth, the
23 whole truth and nothing but the truth in your
24 testimony before this Committee and to respond
25 honestly to Council Member questions?

2 MATILDE ROMAN: I do.
3 MALE SPEAKER: I do.
4 MATILDE ROMAN: Good afternoon
5 Chairpersons Rivera and Levine and members of the
6 Committee on Hospitals and the Committee on Health.
7 I am Matilde Roman, Chief Diversity and Inclusion
8 Officer at New York City Health and Hospitals. On
9 behalf of Health and Hospitals' CEO Dr. Mitchell
10 Katz, thank you for the opportunity to testify before
11 you at this oversight hearing on Transgender and Non-
12 Conforming Family Health Services. Our public
13 healthcare system is a safety net for the uninsured
14 and underserved in New York City. Our mission at
15 Health and Hospitals is to provide care to everyone
16 regardless of ability to pay, immigration status,
17 sexual orientation, gender identify or gender
18 expression. As such, it is a crucial part of our
19 mission to provide affirming services for transgender
20 and non-conforming patients who we recognize continue
21 to experience barriers in access to healthcare.
22 Health and Hospitals serves 1.1 million New Yorkers
23 each year, of which approximately 382,000 are
24 uninsured. A 2015 Needs Assessment published by the
25 New York State LGBTQ Health and Human Services

2 Network noted that transgender and gender non-
3 conforming communities report lack of financial
4 resource as a significant barrier to accessing health
5 services. As a Health and Hospitals we offer a
6 pathway to care for anyone including TGNC patients.
7 We would otherwise not have access to financial
8 resource. We have experienced financial counselors
9 who can assist in screening for eligibility and
10 enroll individuals at every opportunity. Health and
11 Hospitals' financial counselors will work with TGNC
12 individuals to match them with the insurance plan
13 that best meets their needs, Metro Plus example
14 offers comprehensive coverage for transgender and
15 non-conforming people including coverage for services
16 such as hormone therapy or gender affirming
17 surgeries. For those who need financial assistance,
18 Health and Hospitals provides a sliding fee scale
19 payment option call Health and Hospitals Options to
20 make dare affordable for them. The program offers an
21 affordable fee based upon family size and income that
22 covers all healthcare services including those
23 specially related to gender affirming care. Since
24 2015, all of our health system's qualifying
25 facilities have received a designation of leader in

2 LGBTQ healthcare equality by the Human Rights
3 Campaign Foundation's Healthcare Equality Index.
4 This designation demonstrates Health and Hospitals'
5 strong commitment to LGBTQ health equity through our
6 policies, programs and ongoing training. New York
7 City Health and Hospitals has and will continue to
8 strive to provide patient centered affirming care to
9 transgender and non-conforming communities. Despite
10 the uncertainty regarding federal actions that would
11 affect transgender and gender non-conforming
12 communities' access to healthcare, Health and
13 Hospitals remains firmly committed to improving the
14 health of all our patients regardless of their gender
15 identify or expression. We have taken a number of
16 actions over the past several years to make process
17 on this premise.
18 Health and Hospitals' Expansion of
19 Clinical Services: In addressing issues of access to
20 services for TGNC communities, we believe there
21 should be no wrong door in our health system.
22 Transgender and gender non-conforming individuals
23 should be able to access high quality services at any
24 of our Health and Hospitals entry points. We also
25 understand, however, that due to a history of

2 discrimination in and outside of healthcare, TGNC
3 patients may feel more comfortable seeking services
4 at a clinic with their identities and expressions as
5 it's focused. Our Pride Health Centers offer
6 comprehensive primary care services geared to LGBTQ
7 communities. Services include general preventive
8 care and mental health services as well as gender-
9 affirming care such as hormone therapy or referrals
10 to specialists. In 2014, New York City Health and
11 Hospitals Metropolitan opened the system's first
12 Pride Health Center in East Harlem. At Metropolitan
13 we also offer some gender-affirming surgeries to
14 transgender and non-conforming patients. Last summer
15 we expanded the Pride Health Center model with the
16 opening of one at New York City Health and Hospitals
17 Woodhull in North Brooklyn. We have also extending
18 our offerings of TGNC friendly services via the
19 Bridge Program at New York City Health and Hospitals
20 Gotham Spring Street, which offers medical, mental
21 health and other support services to LGBTQ youth and
22 emerging adults, and we continue to explore
23 opportunities to expand services tailored to TGNC
24 communities in the Outer Boroughs.
25

2 Collection of sexual Orientation and
3 Gender Identity Data: With the expansion of data
4 collection about the gender identities of our
5 patients, we will have the ability to implement
6 programs that more effectively work to reduce health
7 disparities impacting TGNC people. Last month we
8 optimized our electronic health record to collection
9 comprehensive information about the sexual
10 orientation and gender identity of our patients.
11 Among other exciting new features, this includes the
12 ability to display a patient's current name
13 regardless of what appears on administrative
14 documents in the patient header. Therefore,
15 minimizing the risk of patients being misgendered or
16 misnamed or accessing health services.
17 Health and Hospitals' Investment in
18 Educating Our Employees: Through collaboration with
19 a number of community partners we continue to expand
20 the educational offerings to staff that built their
21 capacity to provide affirming care to transgender and
22 non-conforming patients. In the past two years, we
23 have launched a partnership with the Boston
24 Children's Hospital to build our pediatric and
25 adolescent providers capacity to care for transgender

2 and on-conforming youth, the first ever certificate
3 of advanced training in LGBTQ healthcare, a
4 comprehensive training program for clinical providers
5 that was co-developed by Health and Hospitals and the
6 Fenway Institute. Clinical trainings for providers
7 on affirming primary care for transgender and non-
8 conforming adult patients in partnership with the
9 Callen-Lorde Community Health Centers, and a workshop
10 specifically for hospital police on preventing
11 discrimination in areas of public accommodation.
12 This program is offered by the NYPD Community affairs
13 bureaus, LGBTQ Outreach Unit.
14 Patient Communication: To make our
15 commitment to providing affirming services to
16 transgender and gender non-conforming patients clear,
17 Health and Hospitals launched the LGBTQ Services Web
18 Page, which outlines our services, non-discrimination
19 policies and relevant contact numbers. We also
20 created and all-purpose email address to handle any
21 inquiries related to LGBTQ services, which is:
22 lgbtq@nychhc.org
23 Support for Transgender and Non-
24 Conforming City Employees: Ensuring transgender and
25 non-conforming New Yorkers have equitable access to

2 high quality and affordable healthcare also means
3 making sure our transgender colleagues across the
4 city have health benefits that meet their specific
5 needs. Last year Health and Hospitals partnered with
6 the New York City Office of Liberal Relations to
7 modify the Citywide Health Benefits Bulletin to more
8 accurately reflect the coverage of gender affirming
9 care that is available to all city employees. In
10 conclusion, at New York City Health and Hospitals we
11 believe transgender and gender non-conforming people
12 deserve equitable and affordable access to high
13 quality healthcare. To that end, Health and
14 Hospitals' mission of safeguarding the health of our
15 patients, our fellow New Yorkers and our city remains
16 unchanged. Thank you for your interest and
17 attention, and we are happy to answer any questions
18 you may have after my colleague presets. Thank you.
19 CHAIRPERSON LEVINE: Thank you, Ms. Roam.
20 DR. DASKALAKIS: Good afternoon, Chairs
21 Levine and Rivera members of the committees. I am Dr.
22 Demetri Daskalakis, the Deputy Commissioner for the
23 Division of Disease Control at the New York City
24 Department of Health and Mental Hygiene. On behalf
25 of Acting Commissioner Barbarella, I want to thank

2 you for the opportunity to testify today. The
3 mission of Health Department is to protect and
4 promote the health of all New Yorkers including the
5 roughly 756,000 people identifying as Lesbian, Gay,
6 Bisexual, Queer, Transgender and Gender Non-
7 Conforming. We aim to address and eliminate the
8 health inequities rooted in historical and
9 contemporary systemic injustices in everyday
10 discrimination. Essential to this work are the
11 department's services, programming and health
12 promotion campaigns that seek to improve the health
13 and healthcare of LGBTQ and transgender and gender
14 non-conforming New Yorker. Better health begins with
15 personal identification and recognition. Thanks to
16 the Council's leadership, specifically Speaker
17 Johnson and the work of the Health Committee in 2014,
18 we paved the way for transgender New Yorkers to be
19 recognized under the law by easing the requirements
20 for obtaining a gender marker change under New York
21 City birth certificate. All people should have birth
22 certificates that reflect their true gender identity
23 and these documents can be critical to access
24 healthcare, employment and other important services.
25 Since 2014, over 1,200 amended birth certificates

2 have been issued to transgender individuals. We hope
3 to see this number increase thanks to the legislative
4 and regulatory changes that will go into effect on
5 January 1, 2019 to allow an applicant to self-attest
6 their gender identify and the addition of a non-
7 binary gender option. I will turn now to the
8 healthcare services the department oversees. Our
9 clinics offer sexual health, tuberculosis and
10 immunization services. Many LGBTQ and TGNC
11 individuals frequent our sexual health clinics in
12 particular all eight of which offer sexually
13 transmitted infection testing and treatment, quick
14 start contraception and expanded HIV care offerings
15 including initiation of HIV pre and post exposure
16 Prophylaxis that's Prep EMPAP, Prep navigation and
17 jump start initiation of HIV treatment. In addition,
18 these clinics offer overdose prevention and syringe
19 availability services and patient navigators and
20 social workers that assist patients in enrolling in
21 Social Service programs such as substance use
22 treatment and counseling. Our work to improve TGNC
23 health goes beyond our clinic doors and includes
24 innovative programs. In 2017, New York City became
25 the first city to issue an LGBTQ Healthcare Bill of

2 Rights, harnessing existing protections in local,
3 state and federal laws to empower LGBTQ New Yorkers
4 to exercise their rights in healthcare settings.
5 This document available on our website and at health
6 centers across the city reinforces the providers and
7 their support staff cannot legally provide LGBTQ
8 people with a lower quality of care because of their
9 sexual orientation, gender identify or gender
10 expression, and tells people where to get help if
11 their rights are violated. Recognizing the important
12 role of community based support in this work, the
13 department finds four grassroots TGNC led and focused
14 organizations to develop their organizational
15 capacity including preparing them to compete for
16 funding for determinates of health programming such
17 as housing, employment, perioperative support and
18 social connection. Since a supportive family is
19 associated with better health outcomes for TGNC
20 individuals. We also provide funding to CAMBA's
21 project ALY, which promotes parental and familiar
22 acceptance of LGBTQ youth. The department has also
23 released a series of publications to promote the
24 health of TGNC New Yorkers including a health
25 bulletin on LGBTQ health with resources for primary

2 care and mental health and sexual health services, a
3 City Health Information publication for physicians
4 regarding providing primary care to transgender
5 adults, and booklets developed with members of the
6 TGNC community that include tips and resources to
7 help transgender, non-binary and gender non-
8 conforming New Yorkers to healthy. We have also made
9 a concerted effort to develop more inclusive social
10 marketing campaigns by featuring images of TGNC New
11 Yorkers including people who ware well known in New
12 York City's TGNC community. We engage TGNC New
13 Yorkers in the early stages of development at these
14 now world renowned campaigns including convening
15 focus groups made up exclusively of TGNC individuals.
16 Recent campaigns, which can be seen surrounding us
17 here include HIV Be Sure, Play Sure, Stay Sure, Bear
18 it all and Least Dose. And if you saw more of me
19 around the city last year, that's because I was part
20 of the provocative Bare it all Campaign that
21 encouraged LGBTQ New Yorkers to talk openly to their
22 doctors about their sex life, substance use, and
23 other issues affecting their health. This campaign
24 aimed to empower LGBTQ New Yorkers to find providers
25 who affirm who they are, and incorporate their sexual

2 orientation, gender identity and gender expression
3 into their healthcare. This ground breaking campaign
4 advises New Yorkers who feel they cannot have an open
5 dialogue with their current doctor and receive the
6 care they need to call 311 or visit the website to
7 connect to a provider with experience caring for
8 LGBTQ individuals. The department website contains
9 approximately 125 healthcare facilities that provide
10 specific services of interest to TGNC individuals
11 such as Puvadol suppression and hormone therapy.
12 Turning inward the department is committed to
13 ensuring that our programs and services are affirming
14 and inclusive of LGBQ and TGNC New Yorkers. Building
15 our Ways to Justice Initiative, by July 2020, all
16 than our more than 6,000 employees will receive
17 foundational training on implicit bias,
18 discrimination, cultural competency, and structural
19 equity with respect to gender identify, gender
20 expression and sexual orientation. Training on
21 gender awareness has already been provided to all
22 staff in our eight sexual health clinics to ensure
23 that clinics are welcoming to LGBTQ patients with one
24 full day of training being dedicated to providing
25 culturally competent care to TGNC patients. Finally,

2 the backbone of public health is data, but for too
3 long, TGNC individuals have not been adequately
4 represented in this data. This impedes our ability
5 to understand the health needs of this community and
6 develop appropriate interventions. At the Health
7 Department we are improving our gender identity
8 collection both in our surveillance and medical
9 record systems. You will now find data for TGNC
10 individuals in our HIV, STI and Hepatitis
11 Surveillance Reports. The HIV Surveillance
12 publications are unique in presenting certain data by
13 current gender instead of sex at birth, and—and in
14 including data sets specific to transgender
15 individuals. The department is actively working to
16 ensure accurate, consistent and affirming data
17 collection across all reportable diseases. In
18 addition, at our sexual health clinics, medical
19 records include information regarding gender identity
20 and sex assigned at birth. This not only makes our
21 clinics more affirming to TGNC patients, but improves
22 the accuracy of our records while preventing
23 misgendering of patients during clinical
24 interactions. In New York City we protect and
25 support TGNC communities, and we strongly oppose any

2 policies that discriminate against anyone based on
3 gender identify and expression. As the Trump
4 Administration continues its assault on TGNC people,
5 it is crucial for the city to remain stalwart in its
6 commitment to health equity. The department has
7 submitted comments opposing federal regulations and
8 other policy changes that are an affront to our
9 gender equity and health equity values. Most
10 recently the department and the New York City Human
11 Rights Commission published an op-ed in Gay City News
12 on the Trump Administration's plan to change Federal
13 Civil Right Law—Civil Rights Laws to define sex as
14 based on biological traits identifiable by or before
15 birth. I've included a copy of this op—ed—op-ed with
16 my testimony today. If this policy is adopted, the
17 TGNC community will face government sanction
18 discrimination, and as New Yorkers we must fight back
19 that the department we continue to work with the
20 community to improve our services, reduce stigma,
21 increase access to healthcare and promote the health
22 of TGNC New Yorkers. Again, I want to thank Chairs
23 Rivera and Levine for holding this hearing today, and
24 I'm proud to be your partner in this work. Thank
25 you. We're ready for questions.

2 CHAIRPERSON RIVERA: Sure. Yes, thank
3 you. A few questions. I wanted to—to go back
4 because in terms of access and-and what you just
5 mentioned in your testimony. There was an article in
6 the New York Times I believe in 2016 that addressed
7 25,000 TGNC individuals as saying they didn't feel
8 they had access in their own neighborhoods especially
9 challenges when it comes to communities of color. In
10 your testimony you mentioned that there 125 health
11 facilities that specifically I guess had information
12 and education related to TGNC health. Is—do you—in
13 terms of what they mention as not having access in
14 their own neighborhoods, are these 125 health
15 facilities all throughout the city? Do you feel
16 they're in certain neighborhoods and—and-and why
17 aren't there more facilities that—that you'll be able
18 to cite?
19 DR. DASKALAKIS: Yeah. So, we—we vetted
20 so I'll actually explain a little bit more about what
21 we did. So, we didn't just sort of find places that
22 had a good reputation. We actually surveyed them and
23 vetted them to actually see if they were truly able
24 to provide the services that we thought were
25 necessary for LGBTQ and gender non-conforming

2 individuals. Our health map includes providers
3 throughout the entire city. There definitely are
4 some areas with fewer providers. So, for instance in
5 Staten Island, the north of Staten Island is where
6 the majority of our providers are that focus on the
7 community, but the rest of them actually are
8 throughout the city. There are pockets so your
9 Chelsea area, your Lower Manhattan does have a lot of
10 providers who actually do the service, but we have
11 representation in five boroughs. The other thing
12 about the LGBTQ community, which is also important is
13 that not everybody seeks care exactly in their
14 neighborhood. So, sort of just providing people a
15 map and a way to sort of identify folks that are
16 lower risk for them to go to from the perspective of
17 being, you know, open about their experience is, I
18 think useful. So, I think we're actually working on
19 improving like in getting more providers on our list,
20 which I think will actually expand the services on—
21 that we have in—in boroughs other than Manhattan, but
22 like I said, we have a lot of representation in
23 Queens, Brooklyn, and—and—and the Bronx. Like I said,
24 the—the—probably our most sparse representation is
25 Staten Island.

CHAIRPERSON RIVERA: Great. So, in terms of H&H hospitals and clinics, do you have physicians who are trained and—and could proper support and care to those who are TGNC?

MATILDE ROMAN: So Health and Hospitals has made a large investment in training and building capacity for clinical staff to ensure that they're providing affirming services. So, we co-develop with the Fenway Institute intensive curriculum on advanced training in LGBTQ healthcare. That includes looking at things from clinical care to transgender youth, clinical care for the LGBTQ community behavioral health services, looking at sexual orientation and gender identity and the collection of that information. And so, collectively what we've done is we've certified a number of our clinical providers and those—that—hopefully, in the coming months we're going to be making that information publicly available so that it will again enhance the work that's already been done with the DOHMH, and letting individuals know clinicians who have actually underwent this certification program.

2 CHAIRPERSON RIVERA: So, you're going to
3 publicly provide information of certified clinical
4 providers throughout the city?
5 MATILDE ROMAN: Who have done the
6 training at Health and Hospitals. Employees who have
7 undertaken this—advanced training in LGBTQ
8 healthcare. The—the thought would be that we're
9 going to be adding that as part of the LGBTQ webpage
10 on Health and Hospitals and make that publicly
11 available.
12 CHAIRPERSON RIVERA: By the time you-
13 around when do you think this information is going to
14 be ready for the public?
15 MATILDE ROMAN: We are working on that
16 now. So, right now currently we've trained and
17 enrolled over a thousand providers within out system
18 to take this training. The hope would be that once
19 individuals have completed the certification program
20 that we will then be able to have them in the
21 database directory, if you will, and include them in
22 the mapping hopefully with DOHMH so that individuals—
23 you'll have more providers that we know can provide
24 affirming services to LGBTQ individuals in particular
25 TGNC patients.

2 CHAIRPERSON RIVERA: Can you talk a little
3 bit about what certification looks like? How does
4 H&H train its staff to provide meaningful care?
5 MATILDE ROMAN: Yeah, so the training
6 programs there are a number of training programs that
7 we launched in the last two years. We've launched a
8 training with Fenway Institute, which carries with it
9 CME credits and allows providers to get kind of seven
10 hours of intense training on LGBTQ services ranging
11 from behavioral health services, clinical care, how
12 to create an affirming environment, and engaging with
13 LGBTQ. In particular TGNC patients. That is one
14 program. We've also offered clinical training to
15 adolescent medical providers and pediatricians on
16 caring from TGNC youth, and that is with Boston
17 Children's Hospital, and in addition to that, have
18 worked collaboratively with Cannon Board (sic) to
19 offer the same services for TGNC adults, and so
20 that's then the kind of array of—of looking at how we
21 build in capacity so that people understand how to
22 provide affirming care, and the goal is to really
23 building that capacity across the system. But we
24 also have the Pride Health Center that are available
25 for individuals who still don't feel comfortable

2 walking to any of our facilities that provide the
3 one-stop shop and holistic approach to care, and that
4 has, you know, the—the gamut of primary care and
5 mental health services that are available in our
6 Pride Health Centers as well.
7 CHAIRPERSON RIVERA: This certification
8 is it and annual thing? Is it one and done?
9 MATILDE ROMAN: Well, the certification
10 program is—is new, and it's a pilot and the goal
11 would be that we are offering that and—and will be
12 providing additional training. So, this is the
13 beginning of a journey for us as how we are
14 continuing—on—providing ongoing training to clinical
15 staff to ensure that they provide clinical care in an
16 affirming and welcoming manner. And so, the goal
17 would be is that once these individuals have
18 completed the certification that we will be
19 introducing more content for them to ensure that (1)
20 they're—they're up to speed with best practices and
21 nowt to create a provider affirming services to
22 patients ,and so this is an ongoing effort on our
23 part. So, this is the beginning stages of a longer
24 pursuit for us to ensure that we are providing
25 ongoing care. So this is not a one—this is not going

2 to be, you know, a one-off for us. Our commitment is
3 to ensure that we provide capacity building in ways
4 that are meaningful, and where we are able to ensure
5 that individuals who walk through our doors are
6 receiving affirming services.
7 CHAIRPERSON RIVERA: And I'll ask about
8 insurance and—and coverage in a second, but I—I hope
9 that—you know, you mentioned pilot program, and I
10 kind of, you know, cringe a little bit because I feel
11 like a—a pilot program is—is a trial for something
12 may or may not work, and I feel like this kind of
13 education and ongoing professional development is
14 something that has to be considered mainstream. You
15 know, I—I hope that we don't rely on certification in
16 the future that when we talk about TGNC health, it is
17 just as common as OBGYN or as primary care. I—I just
18 ask because I think it's so—so critical for this to
19 be ongoing, and—and just everywhere, and—and I wonder
20 how-how many of your patients are members of the TGNC
21 community.
22 MATILDE ROMAN: Well, we—we are
23 collecting data. We're currently analyzing that
24 data, and—and when we finalize the—the analysis, I'm
25 happy to share that information. What we—so just to

2 kind of take a step back and—and kind of reassure the
3 committee about our commitment to the TGNC community,
4 when I mentioned the pilot it was really a reflection
5 of content in ensuring that we were providing the
6 best content to our clinical providers, ensure that
7 they're building their capacity in a way that's
8 meaningful. By no way does that indicate or should
9 be indicated as our steadfast commitment to providing
10 care to all of our New Yorkers including individuals
11 irrespective of gender identity and expression. So,
12 when I was referring to it-referring to the pilot, I
13 was referring to content and ensuring that we're
14 evaluating it to ensure that it's having its intended
15 impact and effect, and that people are retaining the
16 information in a way that's meaningful. And so we
17 are evaluating content in ways that ensure that we
18 are meeting the needs of our—our TGNC patients.
19 CHAIRPERSON RIVERA: And, you know, H&H—
20 the Council first funded in Fiscal Year 2017 through
21 the Young Woman's Initiative, the transgender
22 specific healthcare training and then in fiscal 2019,
23 we actually allocated $150,000 to this work under the
24 Unity Project. Is that going to be enough for Fiscal
25 Year 2020?

2 MATILDE ROMAN: That's a great question.
3 So, I want to thank the City Council for the funding
4 that we have received. Much of that funding has
5 actually went toward the training that I am referring
6 to, and part of the objective for us is to build out
7 this training in a way that makes sense to really re-
8 enforce best practices and ensure that we are really
9 connecting and—and creating an affirming environment
10 and providing affirming care to our patients. And
11 so, you know, funding is always needed for our
12 municipal healthcare system, and because this is such
13 an important segment of our population, we would
14 welcome an opportunity to discuss any future funding
15 opportunities with the City Council.

16 CHAIRPERSON RIVERA: So, in terms of—of
17 data, [coughs] and I—and I know that H&H is under
18 financial constraints, and—and we're working to-to
19 support you with that, in—in terms of data, what is
20 the data like that you are collecting? What's the
21 intake form like, and is that why you can't I guess
22 estimate how many TGNC patients you have in H&H?

23 MATILDE ROMAN: Sure.

24 CHAIRPERSON RIVERA: Are you looking to
25 collect that data now?

2 MATILDE ROMAN: So, if I may explain the
3 process of how we went live with the integration of--
4 CHAIRPERSON RIVERA: [interposing] I just
5 wanted to add to that. Could you at least confirm
6 that you have TGNC individuals reflected in your
7 staff?
8 MATILDE ROMAN: In our Health and
9 Hospitals employees?
10 CHAIRPERSON RIVERA: Right.
11 MATILDE ROMAN: Yes, we—we have 40,000
12 employees and we do have TGNC staff in our
13 employment. I don't have specific numbers for you,
14 but yes and we would—yeah, that's without—that goes
15 without saying. I think with respect to the
16 collection of sexual orientation and gender identity
17 data, an important—just to kind of contextualize the
18 process and how we—we're able to do it, we really
19 need to look at workflows and make sure that we
20 understood where service moments were in the
21 continuum of care, who was asking these questions?
22 Making sure that the individuals that were asking the
23 questions were doing so in an affirming manner. And
24 so, it took a number of key milestones for us to
25 accomplish this and successfully integrate the SOGI

2 (sic) data fields within our electronic medical
3 records. So, it was, you know, dealing with our
4 stakeholders whether it was IT and the Facility
5 Departments to really understand at what point at
6 intake and registration and at in the—in the clinical
7 encounter were the—was the data being asked and
8 collected, and what we've done is to look at how we
9 are creating gender—looking at used names. So, not
10 only are we collecting the administrative documents
11 required by law, we're also asking individuals for
12 their name used, and having that displayed in the
13 header during—in the clinical records so that during
14 the continuum of care, individuals are called by
15 their name used. And also looking at preferred
16 comments as the—kind of the—the two key fields during
17 intake and registration. In the clinical encounter,
18 we had these smart forms that have body parts where
19 physicians can have conversations with their
20 patients, and—and really do proper screening based on
21 body parts, and so we have the Smart Form within the
22 electronic medical records. It's also used by
23 clinicians. Just—just to kind of give you a sense of
24 what we have done so far.
25

CHAIRPERSON RIVERA: Do you feel—so you mentioned providing comprehensive services within H&H and individuals they're disproportionately unemployed HIV positive and homeless. How is H&H trying to address those issues comprehensively? Because based on the data that we've seen, TGNC individuals are more likely to go into a hospital than a clinic, and I wonder if it's because of the wraparound services, or do you just feel that insurance wise that they are just—they have a lot of challenges in terms of denials for gender affirming care.

MATILDE ROMAN: So, every day Health and Hospitals enrolls hundreds of individuals into Medicaid, Medicare, our Essential Plan and qualified health plans. For individuals who are ineligible for any healthcare coverage, we have H&H options. So, to put it simply, you know, no one denied services based on an inability or lack of insurance. We provide care equally to all individuals. So, it's—people that are walking into services through the Emergency Department, we're providing these services to individuals irrespective of their ability to pay. Do I answer your question?

2 CHAIRPERSON RIVERA: Yes. I wonder, you
3 know, in terms of—and I guess maybe through the data
4 that you're collecting, and again I'm—I'm very
5 interested in knowing exactly what that looks look.
6 Why, you know, more TGNC individuals aren't going to
7 some of the clinics, and I know that there are three
8 clinics that H&H is opening on like a smaller scale,
9 more like urgent care in—in—in three of the large
10 locations, and I hope that they take all of this into
11 account. My—my last question before I turn it over
12 to my colleague is about Correctional Health
13 Services. So, this month, actually we had a hearing
14 along with the Criminal Justice Committee, and the
15 Committee on Mental Health, Disability and Addiction
16 and the Sylvia River Law Project said the policy
17 number MED24B at jails is outdate, and fails to
18 address TGNC specific care issues long term. In
19 terms of what's happening at some of the jails and
20 Correctional Health Services, do you feel that CHS
21 staff is trained to provide care to TGNC individuals?
22 MATILDE ROMAN: That's a great question.
23 So, many of the Correctional Health staff have
24 actually been trained in the—the LGBTQ advanced
25 training that we offer, and I also know that during

2 intake exam gender identity and sexual orientation is
3 key questions that are asked for patients when they
4 encounter personal health staff. Is there more than
5 we can do? There's always areas where we can improve
6 and we would love to explore those options with the
7 City Council and make whatever efforts we can because
8 TGNC individuals deserve equitable quality care at
9 every point within our system.
10 CHAIRPERSON RIVERA: Thank you.
11 CHAIRPERSON LEVINE: Thank you very much
12 Madam Chair. I want to acknowledge we've also been
13 joined by Committee members Alicka Ampry-Samuel,
14 Keith Powers and Alan Maisel, who was with us
15 earlier. We still hear stories even in New York City
16 the most progressive city or we like to think of
17 ourselves that way. We still hear stories from TGNC
18 patients about an emergency room visit where they had
19 humiliating questions asked. A receptionist at a
20 clinic who insists on misgendering the individual,
21 the patient. We hear stories of medical providers
22 who say sorry we're not equipped to handle TGNC
23 patients. We know those stories are real and they're
24 a source of a lot of pain for New Yorkers, and one of
25 the takeaways from that for me is that this isn't--

2 not just about the doctor and the physician being
3 culturally sensitive. It's every single person who
4 works in the medical setting from a nurse's aid to a
5 physician assistant to an X-ray tech to the
6 receptionist out front. Anyone who is coming into
7 contact with any patient needs to be culturally
8 competent, trained, certified. So, we have a—an
9 adequate experience from end to end. So, can—can any
10 of you talk about our efforts to extend this cultural
11 sensitivity training to non-physician professionals
12 in these settings?
13 MATILDE ROMAN: Yeah. I can start them
14 and also glad to. So, at Health and Hospitals we
15 agree that in order for us to ensure an affirming
16 healthcare environment for everyone, everyone needs
17 to be trained and our goal is that there is no wrong
18 door or for any entry point within our system. So,
19 we did train all hospital police and will continue to
20 train hospital—hospital police and then in partner
21 with the NYPD LGBTQ Unit, in order for us to execute
22 that we have trained registration staff at intake and
23 registration because they are the front line for the
24 collection of sexual orientation and gender identity
25 data, and we will continue training non-clinical

2 staff as well as clinical staff to ensure that during
3 key moments and—and throughout continuum of care,
4 that we are providing affirming services to LGBTQ in
5 particular TGNC patients.
6 CHAIRPERSON LEVINE: Okay, if—and this
7 might be a question for you, Deputy Commissioner. If
8 a medical provider tells a patient sorry, we're not
9 equipped to serve you, has a law been violated? And
10 if so, are we enforcing that law?
11 DR. DASKALAKIS: So, that reflects really
12 well onto the work in the LGBTQ Healthcare Bill of
13 Rights where we—we have discerned and translated a
14 lot of the New York City, New York State and federal
15 protections that exist in New York to include the
16 fact that folks need to be able to access services
17 where—where they seek them. So, our strategy along
18 with the New York City Commission on Human Rights is
19 that if someone feels that they've gone into a
20 healthcare setting, and they're not offered
21 appropriate care, they can call the Commission, and
22 they will actually investigate it. So, I think that
23 it's—it's—if—if it doesn't violate a law directly, it
24 violates the spirit of a law, and I think it's also
25 something that we recommend folks actually follow up

2 with—with our Healthcare Bill of Rights sort of
3 strategy, which is make sure that people know about
4 it so we can follow up, and by 'we' I mean the—the
5 Commit—the Commission on Human Rights.
6 CHAIRPERSON LEVINE: Okay. So, any New
7 Yorker who is told that they cannot be adequately
8 served essentially a denial of service--
9 DR. DASKALAKIS: [interposing] We would
10 encourage them to call that number.
11 CHAIRPERSON LEVINE: And—and via 311 you
12 can make that connection.
13 DR. DASKALAKIS: Via 311 and also
14 actually a lot of healthcare facilities around New
15 York have—are very similar to the New York State
16 Healthcare Bill of Rights, the General Healthcare
17 Bill of Rights. We provide a poster for the LGBTQ
18 Healthcare Bill of Rights and it's all over
19 everywhere. So, if you leave a facility and you feel
20 like you're not getting service, that's—that's—that's
21 posted, and so, yeah we would encourage folks to call
22 that number because service should be available
23 wherever they seek it.
24 CHAIRPERSON LEVINE: This kind of rule is
25 only as good as the enforcement. If it's not

2 enforced it doesn't help anybody. Has there ever
3 been to your knowledge an enforcement action or a
4 Human Right Commission case take up against medical
5 provider for lack of service.
6 DR. DASKALAKIS: We'll have to follow up
7 with what's actually coming through the Commission on
8 Human Rights. My understanding is they've gotten
9 calls and that they have followed up, but I can't
10 tell you how often or if there's been a specific
11 action. I'm not aware of a legal action, but that's
12 also because I'm just not aware of it. Not because
13 it may not exist.
14 CHAIRPERSON LEVINE: Okay. Both of you
15 talked about efforts to get better data on the TGNC
16 community, and I think we understand the power of
17 that, and the necessity of that. In this era of—of
18 hacking and compromise networks, I think we also have
19 to be really worried about the safety and security of
20 this data and the anonymity, and the extent to which
21 New Yorkers can feel confident that this data will
22 not be compromised. Can you talk about the
23 safeguards for this very sensitive information?
24 MATILDE ROMAN: So we have a number of
25 safeguards within our electronic medical records.

2 You know, we're collecting personal patient
3 information, and so, you know, we have extensive
4 firewalls and precautions and safeguards in place to
5 ensure that we are protecting that information, and
6 that would also include information related to
7 someone's sexual orientation and gender identity.
8 CHAIRPERSON LEVINE: Okay. There's
9 probably no agency in New York City which doesn't
10 need to be competent in dealing with TGNC New
11 Yorkers. [siren] They may simply be filling out a
12 form when you're seeing benefits in which there's a
13 question on gender, and we need the staff person to
14 be sensitive and prepared to handle that. So, Ashe,
15 I'm going to ask you since I presumed that your role
16 in the Mayor's Office is in touch—coordinating
17 amongst the many agencies here, and not just Health
18 and H&H. Do we have a city government wide
19 initiative in place to make sure that everyone in any
20 agency dealing with a member of the public is trained
21 and sensitive on how to adequately and culturally
22 appropriately serve TGNC New Yorkers?
23 ASHE MCGOVERN: Yeah, I mean I would have
24 to get back to you specifically on what individual
25 agencies are doing. I can say for certain CCHR has

2 been very involved in training agencies and agency
3 staff on cultural competency across a range of issues
4 including LGBTQ cultural competency.
5 CHAIRPERSON LEVINE: But am I right that
6 your role in the Mayor's Office in liaising to
7 various agencies.
8 ASHE MCGOVERN: Yes.
9 CHAIRPERSON LEVINE: Is—is that right?
10 ASHE MCGOVERN: Yes, and the Senior LGBTQ
11 Policy Advisor.
12 CHAIRPERSON LEVINE: But is that more
13 outward focusing to community members or is that also
14 inside of city government?
15 ASHE MCGOVERN: It's both.
16 CHAIRPERSON LEVINE: It's both.
17 ASHE MCGOVERN: Uh-hm.
18 CHAIRPERSON LEVINE: So, does each agency
19 then have to develop its own policy around culturally
20 sensitive service to the public?
21 ASHE MCGOVERN: It depends on the agency.
22 Some agencies already have cultural competency
23 training that incorporates LGBTQ competency. Others
24 reach out to CCHR or external partners in order to
25

2 conduct that training. So, it's—it's a little
3 dependent.
4 CHAIRPERSON LEVINE: As we are rightfully
5 holding the private medical sector accountable, we
6 have to make sure that we ourselves are living up to
7 the gold standards so--
8 ASHE MCGOVERN: [interposing] Absolutely.
9 CHAIRPERSON LEVINE: --we just want to
10 continue to push on that front. In addition to
11 sensitivity we also care about capacity particularly
12 for gender affirming surgery and other really
13 specialized treatments, and there's been progress on
14 that front. It's not just Mount Sini, now NYU,
15 Montefiore are offering gender affirming surgery. I
16 believe Bellevue now offers top surgery, but as—as—as
17 of my latest updates, there could still be months
18 longs even more than a year long wait for a procedure
19 with a specialist, and I'm wondering if you can
20 comment in an H&H context or even more broadly about
21 just that capacity question: How long is the wait?
22 What—what I'll say quickly is that the stakes are
23 high because if someone has to wait a year or a year
24 and a half, they might go an unauthorized provider
25 that really could do great harm to—to the individual.

2 That’s how it was in the bad old days, and we don’t
3 want someone to have to be forced to go to the street
4 for either hormone treatment or—or surgery. We want
5 them in a proper medical setting, and—and so my
6 question then is about wait times and capacity for
7 those procedures.
8 MATILDE ROMAN: And so as—as I
9 understand, we currently have very nominal wait times
10 for-at our Pride House Centers. We have the capacity
11 to provide and—and—and to—and we are providing
12 primary care screening that also includes hormone
13 therapy in the primary care setting. We’ve also made
14 extensive efforts to really train clinical providers
15 in other facilities aside form the Pride Health
16 Centers on providing, you know, transgender affirming
17 care. So our wait times are nominal. In regard to
18 specifically to gender affirming surgeries we provide
19 some surgeries at Metropolitan. We started doing
20 some in 2017, and again, our wait times for the
21 Gender Affirming Services are nominal at
22 Metropolitan. So, we’re meeting capacity and meeting
23 the needs of our patient population at this time.
24 CHAIRPERSON LEVINE: One more question
25 and then I’ll pass it out to my—to my committee

2 members. There is one segment of the TGNC community
3 that can't take advantage of Medicaid or Medicare or
4 any of the publicly subsidized plans. So, the fact
5 that discrimination is outlawed in those plans is
6 irrelevant, and that's undocumented New Yorkers who
7 don't qualify at least as adults for any of the
8 publicly subsidized health plans, and the great
9 majority of them live without health insurance.
10 Community Healthcare Network told me that at their
11 facility in Queens of 350 patients—of 350 transgender
12 and—and gender non-conforming patients, 300 are
13 undocumented. So, this is a very significant segment
14 of the community and many of them have no way to pay
15 for any kind of gender reaffirming procedures, and
16 some of them have no recourse other than to turn to
17 survival sex as a way to pay for these bills, and by
18 the way, we need to be arresting the Johns not the
19 sex workers. That's another hearing, but what do we
20 do to meet the medical needs of transgender and—and
21 GNC New Yorkers who are undocumented, and therefore,
22 can't access any of the public plans?
23 MATILDE ROMAN: So at Health and
24 Hospitals we do a preliminary screening for the—to
25 seek qualifying healthcare coverage for those

2 individuals who are ineligible. Case in point,
3 individuals who are undocumented. We do have H&H
4 options, which is our sliding fee scale payment
5 options that allow individuals for no to low cost to
6 receive care. Thad include gender affirming care and
7 services to the TGNC population, and so we are
8 providing services. Our mission is to provide care
9 regardless of someone's ability to pay insurance,
10 gender TGNC (sic) or gender expression. That's true
11 today. It will be true tomorrow, and it will be true
12 in 10 years from now.
13 CHAIRPERSON LEVINE: Well, thank goodness
14 for the sliding scale at Health and Hospitals. Of
15 course, that doesn't apply in the voluntary hospital
16 in other settings, and generally people don't go to a
17 hospital until they are in crisis and giving every
18 New Yorker a chance to have primary care in a
19 culturally sensitive, often community-based facility
20 is really the ultimate goal and—and we've talked
21 about particularly with my colleague Carlos Menchaca
22 about creating some sort of health plan for people
23 who are not insurable on the public plans, which is
24 the undocumented, to get them into a clinic for their
25

2 vaccinations, their annual physical so that it
3 doesn't escalate for the need of a hospital visit.
4 MATILDE ROMAN: We welcome them in Health
5 and Hospitals.
6 CHAIRPERSON LEVINE: I—I know that and we
7 thank you for that, and I'm going to pass it off to
8 our colleague Council Member Reynoso who had a
9 question.
10 COUNCIL MEMBER REYNOSO: Good afternoon.
11 Thank you for being here. I just want to ask a
12 question again. I didn't get the—I didn't hear the
13 answer. It was asked by Council Member Rivera. It
14 was related to employment of the TGNC community, and
15 whether or not we're taking that on as a city, and
16 you just kind of said yeah, we're doing that. I just
17 need a little more detail. Do we know how many
18 employees of the community are in the hospitals in
19 the hospital network?
20 MATILDE ROMAN: So, I don't have firm
21 numbers for you now. We have 40,000 employees across
22 our system and have—are now working toward
23 integrating in our—in our HR People Soft System, a
24 way of people to self-identify. It's critically
25 important for us to ensure that we're not only

2 providing affirming services but also creating and
3 affirming environment for our work colleagues. To
4 that end, the goal would be is to find an opportunity
5 where we're allowing individuals to self-report
6 their—their gender identity and that's something that
7 we're working on now.
8 COUNCIL MEMBER REYNOSO: I would just
9 like to maybe for the future that we get numbers I
10 guess or data or information. I can only imagine
11 being in New York City and never seeing the same
12 Latino face--
13 MATILDE ROMAN: [interposing] Yes.
14 COUNCIL MEMBER REYNOSO: --in Health and
15 Hospitals' Network and then feeling like there's a
16 culture need—a cultural disconnect—disconnect
17 happening, and having someone that looks like you has
18 gone through the same experiences in the room really
19 helps with someone feeling comfortable, and being
20 able to get services especially here in New York
21 City. So, I really want to be more—more direct with
22 that in making sure that you get that—that we get
23 something that's more affirming than just we're
24 working on it or we're trying to be more smarter
25 about how we classify folks and so forth. I think

2 that’s important. I want to talk about your
3 relationship with organizations that work with TGNC
4 members. What is the relationship between Health and
5 Hospitals and these like local organizations that
6 have been doing this work on the ground for a long
7 time?
8 MATILDE ROMAN: So, Health and Hospitals
9 commitment is strong, so strong that about a year and
10 a half ago, we brought on the first Associate
11 Director for Gender Equity, Sarah Bender who could
12 not be here today because she’s in better pastures
13 traveling, but really—it’s really an attempt for her
14 to be doing a lot of the community outreach and—and
15 just recently, had a walk-through and—and many of the
16 Pride Health Centers met, and at Woodhull with the
17 Sylvia Rivera Law Project. We work with them on the
18 legal and we work with a number of other
19 organizations. One, it’s important for us to get
20 feedback, learn what we’re doing well and where there
21 are opportunities for us to improve our services and
22 our engagement. We are actively involved with
23 community and just—and just having interagency
24 collaboration with City Hall just to ensure that we
25 are meeting the needs of our patients and providing

2 affirming services and so—and we will continue doing
3 that. So, we've issues our webpage for LGBTQ
4 services. We have been doing a number of outreach.
5 We've issued a number of—of videos that serve both as
6 reinforcement of our practices our best—our policies
7 and practices for our patients, and also are working
8 closely with community organizations to ensure that
9 we are understanding the need, and working to address
10 it.
11 COUNCIL MEMBER REYNOSO: Yeah, I—I would
12 like to see if we can have time where I can see that
13 type of work happening locally with specifically
14 Woodhull Hospital, which I always try to take an
15 opportunity to bring in as many resources into this
16 hospital, and make sure that we're a premier hospital
17 in the City of New York when it comes to like how we
18 want to move forward. I want to see how we can work
19 with local organizations and just see how the staff
20 there is interacting to see if it's appropriate, and
21 see if we're doing the right thing. I know we have
22 an LGBTQ clinic in—in Woodhull, one of the first and
23 we're very proud of it, but we just want to make sure
24 that we're moving along, and we're just satisfied
25 because we were one of the first. So, we started it

2 but that we keep growing. I do want to ask related
3 to anything that's happening on the federal level
4 especially with Medicaid and Medicare. How it's
5 going to—how we're prepared to protect ourselves
6 against anything that might threaten healthcare for
7 the TGNC population? I just want to know if we are
8 prepared for that and if—if legally we're not—if
9 legally let's say Medicaid and Medicare can't work,
10 what options do we have to make sure that we're
11 continuing to provide services for folks that need
12 it.
13 ASHE MCGOVERN: Sure. So, I can just
14 sort of re-emphasize that in New York City we have
15 some of the strongest legal protections for trans and
16 gender non-binary people in the country, and those
17 protections include protections in hospitals, health
18 centers and also insurance. So, the—the response of
19 the Trump Administration potentially to roll back
20 Obama Era protections for trans and non-binary people
21 in healthcare, there may—may be some implications,
22 but we as far as local protections and state
23 protections go, we're in a pretty good place. Of
24 course, that doesn't mean that stigma won't increase
25 against trans and non-binary people with federal

2 rhetoric as it is, though we do have very strong
3 protections here in New York.
4 COUNCIL MEMBER REYNOSO: So, just educate
5 me. Medicaid and Medicare are federal programs. If
6 federally the President says that you're either M or
7 F, or you're not receiving services--
8 ASHE MCGOVERN: [interposing] Uh-hm.
9 COUNCIL MEMBER REYNOSO: --we can—we—we
10 don't control Medicaid and Medicare. I'm assuming
11 that. So, I just want you to help me through that
12 interaction should that happen where I'm going to
13 have to identify M and F. If I'm an M or F to be
14 able to get services. I can't do that. So what
15 happens? How does the city come in and protect us
16 and protect the TGNC community?
17 ASHE MCGOVERN: Yeah, so, I—I can say I'm
18 happy to follow up with like a little more detail on
19 Medicare in particular, which I know less about, but
20 in a Medicaid context at least we do have state
21 protections around discrimination that are aimed at
22 protecting trans and non-binary particularly in
23 insurance coverage and so should the federal
24 government do what it is saying it will do around
25 redefining protections on—in terms of federal non-

2 discrimination, we still have these state and local
3 protection in place and Medicare and Medicaid are
4 sort of dictated by separate agencies than the ones
5 that we've been hearing might change their roles.
6 So, there could be changes that we haven't
7 anticipated yet or even heard about.

8 COUNCIL MEMBER REYNOSO: I just want to
9 prepare I guess--

10 ASHE MCGOVERN: Yes absolutely.

11 COUNCIL MEMBER REYNOSO: --and just get—
12 get to a place where I feel comfortable because I'm
13 very—I don't know what it is—a gray area there that
14 we're talking about when it comes to healthcare
15 especially Medicaid and we're talking about large
16 population of unemployment, homelessness. So, we're
17 talking about people that are probably going to need
18 Medicaid. So, I really want to get there, and
19 understand that, and then if we—if we can't do
20 something or we're—it's threatening, are we going to
21 sue, and if we're not going to sue, how are we going
22 to compensate and make sure that there is healthcare
23 for all New Yorkers, but I really thank you for your
24 time here, and thank you to our chairs for another
25 great hearing. Thank you.

2 CHAIRPERSON LEVINE: Than you, Member—
3 Council Member Reynoso. I believe Council Member
4 Ayala has a question. I'm sorry. We've been joined
5 by Council Member. Dr. Mathieu Eugene as well as
6 Council Member Inez Barron. Thank you.
7 COUNCIL MEMBER AYALA: [coughs] My
8 question is regarding the—the health centers. There
9 are two health center citywide? Is that correct?
10 MATILDE ROMAN: So, we currently have two
11 Pride Health Centers, one in Metropolitan and one in
12 Woodhull, and we're looking to also expand services
13 to other areas in the Outer Boroughs.
14 COUNCIL MEMBER AYALA: And how often are
15 the health centers available? How—how often are they
16 open?
17 MATILDE ROMAN: So, the programs, I don't
18 have the specific schedule in front of me, but
19 they're often, they're offered—programs are offered,
20 clinical programs are offered several times a week,
21 and individuals can make an appointment either
22 through our call centers or directly with the
23 clinical program and so—and it's been—in 2014 the
24 first Pride House Center was opened in Metropolitan
25 and we just recently opened one in North Brooklyn at

2 Woodhull Hospital, and the goal would be that as—
3 there's an increase in demand and opportunities for
4 us to provide these services in other locations.
5 We're exploring that at this—at this point.
6 COUNCIL MEMBER AYALA: So, the number of
7 days that a clinic is open is determined based on the
8 number of people that are frequencing that clinic?
9 MATILDE ROMAN: Yes.
10 COUNCIL MEMBER AYALA: So, in East Harlem
11 Metropolitan Hospital is in my district.
12 MATILDE ROMAN: Uh-hm.
13 COUNCIL MEMBER AYALA: We opened in 2014.
14 I'm very excited about that and I, you know, I brag
15 about it, but my understanding is that it was only
16 open on Saturdays. Is that still the case? Because
17 it's been four years?
18 MATILDE ROMAN: I believe that there—
19 they've expanded services for two times a week I
20 believe. I don't know if it's Wednesday or Saturday,
21 but I'm not quite sure, but it really is contingent
22 ono volume and demand and as in—and as we increase
23 the panel for our patients, we then increase
24 services.
25

2 COUNCIL MEMBER AYALA: So, if a—if a
3 patient that identifies as TGNC is seeing a primary
4 doctor at one of the hospitals that is participating,
5 is that primary care doctor then referring them to
6 the clinic as an option?
7 MATILDE ROMAN: It could be an option or
8 the primary care physician can meet the needs of the
9 patient. So, it really a case-by-case—on a case-by-
10 case basis. If there is screening and preventative
11 care and our physicians have been trained, and—and
12 have the capacity to provide affirming care, that
13 individual can seek services at any one of our
14 facilities. The Pride Health Center really is
15 intended to be a one-stop shop for individuals who
16 may not be comfortable just walking into any one of
17 our facilities, but want to be—feel like they're in
18 an environment where their gender—gender identity and
19 expression is the focus of care for them, but
20 services can be provided in any one of our locations.
21 COUNCIL MEMBER AYALA: And what is the
22 difference between a health center and the—the Bridge
23 Program?
24 MATILDE ROMAN: So, Bridge Program is—
25 it's on Spring Street, and it's related and geared

2 toward youth with an expertise in LGBTQ services, and
3 so it provides primary care, screening for young
4 adults, emerging adults and adolescent youth with a
5 specialty in LGBTQ youth services.

6 COUNCIL MEMBER AYALA: Okay, and I think
7 that it was—I think maybe the Department of Health
8 mentioned that the Bronx doesn't happen to have a
9 health center because it's rich in resources. What
10 are those resources? Where do they exist?

11 DR. DASKALAKIS: We have a lot of
12 providers in the Bronx, non—non-H&H, and also H&H
13 that provide services and it made our Health Map and
14 our list. So, including Montefiore, the Adolescent
15 Program there. We have again all of the hospitals
16 and—and the clinics at H&H. I think you said it
17 there HRC certify and so I think there we—we refer
18 folks there all the time. So, really Bronx actually
19 is interesting because in general it has a lot of
20 service providers and a lot of community based
21 organizations that work really well together. That's
22 evidenced by the fact that one of our greatest
23 examples, which does touch the TGNC community is our
24 working in the New York Knows Program. Bronx Knows
25 was the first program to sort of launch a local

2 effort to increase HIV testing. It's just an example
3 that they're the most successful in the city where
4 they've actually reached 96% of people with HIV aware
5 of their—their status. Though a big area, we have a
6 lot of providers that do—do provide service and also
7 a lot of community based organizations including some
8 of the grassroots ones that we find that are located
9 in the Bronx.
10 COUNCIL MEMBER AYALA: They're great at
11 connecting people to services, but I wonder if the
12 services that are there are connecting people to
13 necessarily services they—they are looking for.
14 Because I agree that we have—I—I love the Bronx one.
15 Like I mean I was at the 10th year anniversary
16 celebration recently, but are they connecting people
17 to the Bronx? Like how many-how many of our
18 hospitals are equipped with providers in the Bronx
19 that are trained to deal with this population right?
20 DR. DASKALAKIS: We can—we can get back
21 to you from the Health Map to tell you how many
22 facilities and how many providers we have that are in
23 the Bronx. I don't know off the top of my head, but
24 in general that's an area that's not particularly
25 underserved from our perspective in terms of density

2 of provider. You have awareness and—and facility at
3 providing LGBTQ Health. I thin that in general,
4 though I think the—that from the transgender, gender
5 non-conforming perspective, you know, I think you
6 have to be very specific about the services that
7 people need and one of the efforts that we made in
8 our Health Map is to not just say Trans Health or
9 gender non-conforming health, but if you—you want to
10 find someone who does Puvadol suppression, you can
11 search that. You cant to find someone who can do
12 certification letters, we've—we've got that. People
13 who do hormone therapy. So, we want to make it
14 easier for people to really find what they need
15 rather than just like clump everything together in
16 one big storage I think is also what H&H is doing.
17 COUNCIL MEMBER AYALA: Understood. Thank
18 you.
19 DR. DASKALAKIS: Thank you.
20 CHAIRPERSON LEVINE: Alright. Thank you
21 very much to the Administration. Whoops.
22 CHAIRPERSON RIVERA: [off mic] I have a
23 question.
24 CHAIRPERSON LEVINE: Forgive me. Chair
25 Rivera.

2 CHAIRPERSON RIVERA: I just have a—I just
3 have a few more. The first one is—is back to the—to—
4 to data. So, right no—Council Member Reynoso
5 mentioned a little bit about the data that you're
6 collecting and I know that you said you're in the
7 process of it, and you're not sure when it will be
8 released to the public, and I've you a little bit
9 about what it looks like, but I—I don't-I don't
10 really—I don't think I got an answer, but can you at
11 least say that based on the data that you've
12 collected that you can in many ways kind of assess
13 and determine what are the experiences and some of
14 the health outcomes in the TGNCNB community?
15 MATILDE ROMAN: So, the goal would be
16 that the data that we collect will serve for us to
17 really understand the health disparities and more—
18 more detailed health disparities that are happening
19 with-with the TGNC community, and so asking, you
20 know, for gender identity is the first step in the
21 process of really then being able to stratify the
22 data against a number of health outcomes and other
23 issues impacting the TGNC community that will help us
24 and allow us to then craft preventive and
25 intervention strategies to really eliminate the

2 barriers and improve the health outcomes for TGNC
3 patients, and so that would be the goal. So gender
4 identity looking at it not just from sex assigned at
5 birth, but the expansive spectrum of gender identity
6 is what we've done in the collection of our data
7 fields.
8 CHAIRPERSON RIVERA: And—and through this
9 data are there programs opportunities identified that
10 are going unfunded that could benefit the TGNCNB
11 community? Well, we—we want to partner with you,
12 and—and we want-we realize that funding is always an
13 issue. So, if there are opportunities or—or programs
14 that are going unfunded that there's incredible
15 potential and opportunity, and there are people in
16 this room that can surely help identify and I do have
17 a question about TGNCNB liaisons for the TGNCNB
18 community. Are you speaking with them? Are you
19 working with them to develop programs that we could
20 potentially fund as a Council?
21 MATILDE ROMAN: So, we always are excited
22 and willing to partner with City Council and members
23 of the community to find strategies and solutions to
24 help support the TGNC New Yorkers. That goes without
25 saying, and we are aware of the advocates' requests

2 for funding for the liaisons. I'm happy to have
3 those conversations and to explore that further.
4 What we also are doing is to really build capacity
5 for our current patient navigators because again as
6 to Mr. Levine's point, in having, you know, you know,
7 clinical affirming training is one think but before
8 you get to the provider, you need to ensure that
9 affirm—affirming a welcoming event is happening from
10 the point of entry to the point that you see the
11 physician. And so part of our strategy in the no
12 wrong door approach is to build capacity to non-
13 clinical staff, and that would include patient
14 navigators, community health workers. So that they
15 can provide affirming services throughout Health and
16 Hospitals.
17 CHAIRPERSON RIVERA: And I wholeheartedly
18 support the advocates' request for this sort of
19 consideration. I think it's really important, and I
20 say that because we could talk about diversity until
21 we're blue in the face but it is all about
22 representation, and for someone to see themselves
23 represented in staff in the hospital system is
24 incredibly important. So, I wanted to ask what
25

2 specific initiatives has your office implemented to
3 ensure a diverse workforce?
4 MATILDE ROMAN: So, we're exploring
5 talent acquisition opportunities where we're reaching
6 out and sourcing to identify individuals who can
7 apply for positions at Health and Hospitals. That we
8 do, and we will continue to do so, and it's really us
9 understanding where there are opportunities for us to
10 leverage. I—I agree with you that, you know,
11 representation is important, and the hope would be is
12 that as we're ensuring that our staff is reflective
13 of the communities in which we serve, that we are
14 making a concerted effort, and my office is making a
15 concerted effort to ensure that we are, you know
16 casting wide net, and ensuring that we are sourcing
17 in—in creating opportunities for individuals to seek
18 employment at Health and Hospitals.
19 CHAIRPERSON RIVERA: My last question is
20 about costs. We had a hearing, Chair Levine and I
21 just earlier this month in the disparities in costs
22 among the entire healthcare system specifically among
23 hospitals, and I know that many employers sponsored
24 insurance plans cover TGNC services, but still there
25 are a lot of out-of-pocket costs for this particular—

2 for these particular New Yorkers. What types of
3 programs are available to help cover these costs?
4 MATILDE ROMAN: So for individuals who
5 are not eligible for whether that be Medicaid,
6 Medicare, essential plan or a qualifying health plan,
7 we have H&H options that cover the costs and, you
8 know, the goal would be is that we're providing care
9 to everyone irrespective of their ability to pay, and
10 irrespective of insurance, and as a fallback, we have
11 H&H options. That for nominal fees people can seek
12 gender affirming care at any one of our Health and
13 Hospitals facilities.
14 CHAIRPERSON RIVERA: And I ask because
15 the price of gender affirming care and surgery is
16 very different between a private surgeon and a public
17 surgeon, and I wonder whether you can explain why is
18 it so different for example for breast augmentation?
19 MATILDE ROMAN: I'm unable to answer that
20 question as I—I don't know the difference, but we do
21 offer it a Metropolitan. So we are offering top
22 surgery at Metropolitan Hospital since 2017, and the
23 panel has grown at Metropolitan, but I don't know the
24 difference.
25

2 CHAIRPERSON RIVERA: It’s, you know, our—
3 our hearing was I guess enlightening in the way that
4 the people, you know, it was—the blame was put on the
5 insurance companies and the insurance company blamed
6 the hospital itself, and so it actually left a lot of
7 mystery to an already very complicated process
8 unfortunately, which is just a disservice to New
9 Yorkers and I—in the end I just want to ensure that
10 when we talked about the training because I think
11 that’s important, and I know that I’m—I’m going away
12 from the cost question, but that when Council Member
13 and Chair Levine mentioned non-medical professionals
14 whether it comes to administrative services or even
15 the NYPD, that are present in your hospital systems,
16 it’s really, really important that it is TGNC and the
17 individuals, you know, conducting those trainings,
18 and I will always support that. So, I know that you
19 all are working hard, and we—and we appreciate all
20 that you do, and we hope to be partners in the future
21 to support all of these initiatives. And again, if
22 there are programs unidentified that we can work
23 together with the advocates in this room to fund, I—I
24 would be happy to support that 100% and champion that
25

2 cause, and with that, I'm all done with questions.
3 Thank you.
4 CHAIRPERSON LEVINE: Alright, thank you
5 very much, and thank you to the Administration for
6 speaking, and we're going to call up our next panel,
7 which is Barbara Warren from Mount Sinai.
8 [background comments, pause] I think it's Nathan Levy
9 from the New York NYU Langone. Forgive me if I'm
10 mispronouncing and Kimberly Smith from Callen-Lorde.
11 [background comments, pause] Okay, Barbara, do you
12 want to start us off?
13 BARBARA WARREN: [off mic] Certainly.
14 [pause] Is this on now? It is. Okay. Hello,
15 everyone, good afternoon to everyone on both
16 committees and the—the Chairperson Rivera and
17 Chairperson Levine. My name is Barbara Warren. I am
18 the Director for Lesbian, Gay, Bisexual and
19 Transgender Programs and Polices in the Office for
20 Diversity and Inclusion in the Mount Sinai Health
21 System. I also hold a faculty position as an
22 Assistant Professor of Medical Education at Mount
23 Sinai's Icahn School of Medicine, and I am here this
24 afternoon to talk a little bit about what we've been
25 doing in the Mount Sinai Health System, and also in

2 the School of Medicine around increasing capacity to
3 deliver culturally competent and clinically competent
4 care across the spectrum of care to TGNNB Transgender
5 and Non-Binary patients and prospective patients,
6 healthcare consumers. I'm not going to read my
7 testimony verbatim because I—I—there's a lot of
8 background in there about Mount Sinai and who we are
9 and what we do, and I think most of you are
10 acquainted with us. I do want to talk about a couple
11 of initiatives, though today that I think are really
12 important and—and actually address some of the
13 questions and concerns that have already come out in
14 the testimony today and in your questions to the—the
15 folks that testified on the panel. And there's a
16 couple of things. You know, we start—I have actually
17 been in the system now for seven years as the
18 designated LGBT point person for the system. I was
19 hired back in 2012 by Beth Israel Medical Center,
20 which is part of then Continuum Health Services,
21 which was—is now part of the Mount Sinai Health
22 System. I was actually the first full-time fully
23 designated LGBT point person anywhere actually in the
24 country that was holding this position full time in a
25 large healthcare system to oversee and help

2 facilitate system transformation around LGBT
3 inclusive care. So, actually with that appointment
4 and then up through now with Mount Sinai being merged
5 with Continuum, I—I've been doing this for about 7
6 years and the caveat I just want to say is we are
7 work in progress. I'm—I'm not here to say oh, solved
8 it, done everything is perfect, Mount Sinai is
9 perfect. There's lots of challenges in a very large
10 urban healthcare system with over 45,000 employees
11 across eight, now eight hospital sites and a large
12 medical school, but one of the largest ambulatory
13 care systems in the state as well as the largest
14 graduate medical education training program in the
15 country. They have 2,600 residents who are our house
16 staff across all of our facilities and in all of our
17 sites. So, given that, it's a lot of work to do to
18 make sure that everybody is equipped with the skills
19 and the resources to serve all of our patients
20 including our LGBT patients competently and
21 affirmatively, and that is a work in progress, and we
22 do a lot of training and education, and we've got a
23 lot more to do, and that includes frontline staff,
24 security guards, healthcare providers, et cetera.
25 So, that's something I've been sort of overseeing and

2 facilitating now for the last seven years, and I
3 would say that probably to date we've trained close
4 to 15,000 folks, but we have 45,000 employees, and
5 we're always trying to find better ways to impart the
6 information. The ideal would be certainly for
7 everybody to have ongoing in-person perfect training,
8 but the real is that we are trying to use many, many
9 methods to get information across to ensure that
10 people are in compliance with legal and regulatory—in
11 compliance issues, both at the state and city level
12 as well as nationally. So, and the clinical issues as
13 well. [bell] So, all of that being said, there's a
14 couple—am I over?
15 CHAIRPERSON LEVINE: [off mic] Yes,
16 ma'am. (sic)
17 BARBARA WARREN: Gee. Well, there's a
18 couple of things like, yeah. Wow, that wasn't very
19 long. There's a couple of things I want to highlight
20 that we've been doing, and there's one thing in
21 particular I really want to highlight given what you-
22 you were talking about earlier, and that is the need
23 for a more highly qualified workforce across the
24 system particularly in the clinical area, but across
25 the whole system. Mount Sinai for the last couple of

2 years we have been investing in education and
3 training not as ret—not just retroactively, but
4 proactively. We have—we have a medical school, a
5 nursing school; Administration in—a Medical
6 Administration program; Healthcare Leadership
7 program; and a really large Fellowship program and
8 Bio-Medical Training Institute. We have worked on
9 integrating content around LGB and Transgender and
10 Non-Binary clinical and educational material
11 throughout our four-year medical curriculum and our
12 Residency Training program and our Masters in Public
13 Health program and our Nursing Curriculum, and this
14 is something that I'm rally proud of. We've done a
15 really great job, but we're still working on it. We
16 want to train people before they get to the point of
17 care so that we don't have to keep going back and
18 retro it—retroactive educate everyone. So, that's
19 something I think that's really important. To that
20 end we also do a lot of training and education that
21 we make available to our colleagues around the city
22 including we started the first ever live surgery
23 conference. You know, I hear that you want to
24 increase capacity, and have more people be available
25 to train people, but also I don't think it's fair to

2 expect folks of transgender identity experience to go
3 see people because they're—because the providers are
4 mandated to provide services that they're not
5 competent to provide. I really worry about that. I—
6 I know that there's some regulatory compliance
7 that's—that's there to get people educated, but I
8 also am worried about saying oh, you mandated it.
9 You have to treat this person. You can't turn them
10 away. If you're not qualified to treat that person—I
11 know I wouldn't want to go to somebody that wasn't
12 trained and qualified to treat me just because they
13 were mandated by law that they had to provide
14 services. So, to that end, we've been working really
15 to—to do education and training that's meaningful,
16 and that really enables people to provide the best
17 and highest quality healthcare and that's actually
18 from the get-go from the beginning of their education
19 and training. The other thing I want to highlight
20 that we've been doing, and we could use some more
21 support around that. We really could use—we're
22 having another live surgery conference at the end of
23 February, beginning of March. We'd love to make it
24 available to more people. The surgeons pay for it—
25 pay for it to go, but we'd like to be able to

2 scholarship more people. We want to start an
3 integrated youth gender center, and then one last
4 thing I've got to tell you about because it's been my
5 dream come true, but we need funding and support
6 around it, and that is our—we have a lot of pipeline
7 programs, and this year we were able to get a small
8 amount of funding to create designated internships
9 for folks of transgender identity and experience at
10 the high school level and college level in our
11 pipeline programs. Their medical and nursing
12 education, healthcare administration training
13 programs, and there's training. There's education,
14 there's paid internships and we started a pilot last
15 summer. We got funding to actually have designated
16 internships. We really need to make healthcare
17 education and training available to—to more folks of
18 transgender identity experience to meet some of the
19 things that you were talking about such as having-
20 being able to go see a provider who represents who
21 you are in your community.
22 CHAIRPERSON LEVINE: Thank you, Dr.
23 Warren for you remarks and for being way, way, way
24 ahead of society in general, and—and-and meeting in
25 this space and—and—and you've helped make Mount

2 Sinai one of the leaders globally. Sorry for the
3 rushing on the time we have just yet.
4 BARBARA WARREN: Please don't be sorry.
5 CHAIRPERSON LEVINE: We have a long list
6 of people who want to speak, and so I just want to--
7 BARBARA WARREN: [interposing] Yeah,
8 that's okay.
9 CHAIRPERSON LEVINE: --give everyone a
10 chance to--
11 BARBARA WARREN: You have it in writing,
12 so--
13 CHAIRPERSON LEVINE: We do indeed. Thank
14 you. Please.
15 NATHAN LEVITT: Hi, everyone. I'm Nathan
16 Levitt. I'm the—I'm at NYU Langone Health. I'm a
17 Nurse Practitioner Coordinator in our Transgender
18 Surgery Program. So, a lot of what I have here—I
19 just want to thank everyone in the Council for
20 inviting us to speak. This is a wonderful
21 opportunity. A lot of the information I have here is
22 about the barriers for transgender people in
23 healthcare, which we've gone over a lot today I know.
24 So, I'll sort of skip through that, but I would say
25 as a transgender person myself in this role working

2 with trans patients, it's a really amazing
3 opportunity and I really appreciated your push for
4 hiring and representing trans—the transgender
5 community because it's so important that there's—that
6 we're involved in this and that we're seen as people
7 that can give feedback that are connected to the
8 community. So, that's really important. I think my
9 role in working with transgender patients going
10 through a life changing experience of surgery is so
11 incredibly important for them to see someone that
12 represents them for them to see someone that
13 understands the barriers that they face as so
14 important. So, I really appreciate your focus on
15 that, and I train healthcare providers throughout the
16 city and the country on—specifically on transgender
17 healthcare whether it be through surgery, healthcare
18 providers, from the front desk to the provider level
19 and I—I know how important this training is, and how
20 it really doesn't—it needs to be more in the health
21 professional schools, which I know is what Sinai is
22 doing, Callen-Lorde does and also NYU Langone does as
23 well. And so, what we do at-at NYU Langone, we've
24 recruited one of our surgeons Dr. Bluebond-Langner
25 who works with our patients providing all sorts of

2 gender affirmation surgeries. Our RN who is here
3 with us today, Kevin Moore who represents LGBTQ
4 population and helps really access services for
5 people helping in a system that's obviously, you
6 know, traumatic for people, discriminatory for
7 people. So, he helps create that access for people,
8 and we are training throughout our healthcare system.
9 So with NYU Langone Health, with the nursing school,
10 within the medical school to make sure that every
11 part that are—we call them touchpoints, every point
12 that a transgender person could reach within the
13 health-within the health system, within the mental
14 health provider system is trans sensitive and that
15 requires so much work, and making sure that we also
16 have a trans patient in the Family Advisory Board,
17 which helps us to know what are the issues in the
18 community? Are we doing the best job that we can do?
19 How are patients and family member and their
20 caregivers involved as well. In addition to that, we
21 also started surgery classes, which help our patients
22 understand what is coming up ahead, what are some of
23 the mental health issues that might come up before or
24 after surgery? How do we connect people with
25 community? How do we make sure that people are

2 getting the best surgical outcomes, but also the best
3 mental health outcomes they can in a system that can
4 be very, very difficult for a lot of people? We're
5 also working on our electronic medical records to
6 make sure that people are called the name that they
7 have chosen, the pronouns that they go by, but that
8 is beyond pronouns and names is also what language do
9 they use for their body parts? How do we make sure
10 that every part of this is affirming for people? How
11 do we make sure that we move away from what's very
12 gendered, women's health or men's health and really
13 just what do you have on your body? How do you take
14 care of it, which is what we're really working on.
15 We work on a bed policy to make sure our trans
16 patients are in the—the room the gender that they
17 identify in. So, we have a new hospital that has
18 single rooms so that makes it a lot easier for our
19 patients, and [bell] we just basically say nothing
20 for transgender people without transgender people and
21 that's incredibly important to us. I just want to
22 thank you for the opportunity to speak today.
23 CHAIRPERSON LEVINE: Thank you. It's so-
24 so important to have your perspective and thank you
25 for your work Nathan. Kim.

2 KIMBERLY SMITH: Hi. Hi, Good afternoon
3 and thank you so much for the opportunity to testify
4 before you today. My name is Kimberly Smith. I am
5 representing Callen-Lorde Community Health Center.
6 You probably know that Callen-Lorde Community Health
7 Center's mission is to reach lesbian, gay, bisexual
8 and transgender communities as well as people living
9 with HIV with sensitive high quality and
10 comprehensive healthcare regardless of ability to
11 pay. The three locations last year we served
12 approximately 18,000 patients, more than 4,000 of
13 whom identify as transgender or gender non-binary.
14 I'm going to also not read verbatim and try to cut to
15 the chase so to speak. So, we are observing here in
16 New York that the increased access to public and
17 commercial insurance coverage for gender affirming
18 care and surgeries is doing for transgender
19 individuals what PREP Pre-Exposure Prophylaxis did
20 for HIV negative gay men, and that is to provide a
21 gateway to primary care and this gateway is a great
22 opportunity, but it also is revealing many complex
23 challenges that—that our TGNB patients face in
24 accessing and navigating healthcare and achieving
25 health equity. For example, our patients routinely

2 report discrimination in all forms of healthcare
3 including emergency room and specialist visits. Some
4 have substance use issues, and there are not LGBT
5 specific substance use treatment centers are not
6 enough for us to refer them to. They face
7 homelessness and have no LGBT specific adult shelters
8 for us to refer them to. There are limited providers
9 in New York State including surgeons that are
10 educated on TGNB care, and even well meaning
11 physicians do not get the training they need to
12 adequately serve TGNB patients. So, while the
13 insurance coverage is a huge step forward, TGNB
14 people accessing health services that they need. We
15 need a larger network of TGNB competent providers of
16 both health and social services to come together to
17 address these challenges. So, Callen-Lorde we
18 actually internally have formed a working group to
19 look at these challenges and while it has just
20 launched, I want to offer a few initial
21 recommendations as potentially applicable for the
22 city to consider. One is to create and fund a model
23 of integrated citywide network of services that would
24 specifically support and address TGNB health access.
25 This network would include a coalition of agencies

2 that share a common vision towards helping TGNB
3 patients meet their goals and improve their health
4 outcomes and there's more specificity in my written
5 testimony on that. Two, secondly is to—that we need
6 to continue to track and aggressively fight against
7 healthcare discrimination specifically insurance
8 denials for gender affirming care and surgeries, and
9 even with the state level, legal and executive
10 rulings, moving restrictions on medically necessary
11 healthcare for transgender Medicaid and commercial
12 plan recipients we're finding that folks are still
13 being denied. Approximately 16% of our patients who
14 have—are seeking surgeries a or gender affirming care
15 have been denied access because of the insurance
16 coverage, and while we are seeing some promising
17 steps in this area, this is something that we urge
18 the City Council to support to continue to enforce
19 these regulations and help monitor and track and
20 address these issues locally. [bell] Finally, we
21 would urge the New York City Council to increase its
22 investment in transgender equity and LGBTQ specific
23 funding initiatives that promote transgender health
24 and economic security. It's—the sustaining funding
25 will be critical to supporting TGNB leaders or,

organizations and a range of services that ultimately can address health access and the drivers of health inequity. So, thank you so much for allowing me this opportunity.

CHAIRPERSON LEVINE: Do—do you—do—do any of you--and maybe I'll—I'll you Barbara—-have thoughts on what the broader system needs to do to ensure qualified staff? Your own operations are running according to very high standards, but in the broader world, what—what can we as policymakers do?

BARBARA WARREN: Well, I can tell you we don't have enough qualified staff even though we have very high standards. I think supporting and—and, you know, it's interesting because like the three of us for example we've been working together across our systems for a number of years. We do a lot of training and—and education across our systems, but I think two things: I think finding a way to support folks coming into training programs that are in the city including like some of our—our medical training-our—our—I'm sorry. Our school programs giving people access to scholarships to attend some of the training that exists. I also—you kept using the word certification and I have to say there really—

2 certifications to me a legal term that—that
3 establishes like what somebody's qualifications and
4 credentials and training is to meet certain needs.
5 There really isn't a certification in transgender
6 medicine. The World Professional Association for
7 Transgender Health has just started one, but it's not
8 legally recognized certification. So, I just—I don't
9 want to misuse that word too—too much, and I think
10 maybe them looking into it, maybe the taskforce that—
11 that Kim really was talking about could look into can
12 we establish some kind of a—a standard and a
13 certification across some different disciplines
14 around transgender medicine and then support that by
15 scholarshipping people into those training programs.
16 NATHAN LEVITT: Yeah, I—I would agree. I
17 would also say the work that—that we all do also in
18 health professional schools so I will talk to people
19 about how this isn't transgender medicine separate
20 from everything else, right. So, like we think about
21 our patients at NYU Langone. They might have
22 surgical issues. They might also need to come in for
23 a PAP smear. They might need to come in for a
24 prostate scanning, all of the things that are
25 connected. So, making sure that trans health is a

2 part of each discipline is incredibly important. I
3 think that can help in talking—funding more trainers
4 to come into health professional school so that when
5 people come out of school, social workers, nurse
6 practitioners, nurse, RNs are more adequately
7 equipped to deal with this.
8 CHAIRPERSON RIVERA: Yeah. I mean I agree.
9 I try to—I try to ask that question. In a way I just
10 feel—I don't think it's, you know, anything is—this
11 is just-these are New Yorkers, you know, and every
12 New Yorker should be treated equally. So, I—I do
13 have a question since—since you are two voluntary
14 hospitals in term of cost and billing. Do you—do you
15 find that TGNCNB individuals are-are denied more
16 often than not? I know you're working on 73 active
17 denials but, you know, there is that—that
18 conversation that is—that is commonly had in New York
19 City in terms of public versus private services, and
20 I wonder, you know whether, you know, in terms of
21 TGNCNB services, you know, how ware you kind of
22 addressing at least hat I feel is—it could be
23 misinformation but how are you addressing that?
24 I'm going to give you the honest answer
25 to that.

2 CHAIRPERSON RIVERA: Yes, if you're—Right.

3 KIMBERLY SMITH: The honest answer is

4 that we—every time we have to bill an insurance

5 provide for services, we have to fight to get it, and

6 one of the problems is even though there's this

7 mandate at the New York State level that if you don't

8 make sure who does business in New York State, you

9 have to cover transgender related care. There's no

10 mandated criteria so they're all using different

11 criteria for people to have to demonstrate that

12 they're eligible for the care or some of this is

13 outdated standards of care. So, what we do is we

14 provide our patients, and I'm sure you all do the

15 same. We have people that we hire just to do the

16 financial negotiations with the insurance company on

17 behalf of our patients. Sometimes it's easier than

18 other times, but you never know, and so we find

19 ourselves spending a lot of time trying to get people

20 pre-approvals for all kinds of services that are

21 related specifically to transition. Not necessarily

22 to standardized care, but specifically to transition

23 related care, which is hormones and-and surgery.

24 BARBARA WARREN: And I agree. We also

25 have a social worker that helps at least put out

there what are the things you need to have in place because the trans you already have so many barriers and burdens on them so we try to take that off, but I would say it's also really frustrating because it keeps changing. So, sometimes we'll know what you need for the insurance letter and then they'll change that, and I would say it's particularly difficult for youth. It's very difficult for us to get young people, and we have people as young as 13, 14 coming in for top surgery and there's a lot denials there. So, we do a lot of advocacy work, but it's very difficult.

CHAIRPERSON LEVINE: [off mic] Okay, if you have a quick one? Alright, [on mic] well thank you very much to this panel, and for your leadership in this area, and we'll call up our next panel including Brianna Silverberg who I know has to leave. So, we'll give her an opportunity to start us off. Cecelia Gentile (sp?) also from GMHC. Oh, Freddy Molano from Community Healthcare Network, and Chelsea Goldinger from the LGBT Center, and—and Brianna, if you had to leave, don't hesitate to kick us off.

BRIANNA SILVERBERG: Thank you. So, I mainly learned about personal experiences dealing

2 with—having trans health in New York City. So, that
3 will be what I'm addressing today. So, Good
4 afternoon, Chair Levine, Chair Barron, and all
5 assembled. Appreciate you guys taking the time to
6 put his hearing together. My name is Brianna
7 Silverberg. I work in the Policy Department of GMH.
8 I'm an intern and a trans woman and a proud native
9 New Yorker. What I want to address today is my
10 experience navigating trans healthcare in the city,
11 and some of the disappointments, potholes and sort of
12 divits (sic). I've dealt with from what are supposed
13 to be among some of the most aware and accommodating
14 providers in the ways that concerns me and the sort
15 of general indications that that seems to imply. I
16 first became a patient of Aperture (sp?) which is
17 very surgical (sic) healthcare and then a primary
18 care service in October of 2016, and when I went
19 there I was very excited. I was eager and a little
20 scared and battered, and I was honest with my primary
21 care physicians about some of the anxieties I had
22 starting hormone replacement therapy. Would I lose
23 interest in hobbies? How would I change? What kind
24 of person would I be and how would this treatment
25 affect me? Instead of getting sort of just

2 reassurances about these concerns I had and yet an
3 attempt to sort know I was safe and a welcoming space
4 for me, my nurse practitioner kind of heard all she
5 needed to for my initial concerns. I would start on
6 the lowest does of estrogen that you can really get
7 for daily treatment, which is 2 milligrams of
8 Estradiol taken orally and Spironolactone, which is a
9 common anti-Androgen given to trans women in
10 transition, and the reason I bring this up is it's
11 hard to convey how much I was sort of the dictionary
12 definition of cross-pollen. The day that I came in
13 three months later to see my blood work and that my
14 blood levels have barely budged. My testosterone and
15 estrogen levels in my blood stream were essentially
16 unchanged as if I never started HRT and it took
17 literally years until I had gotten to a point where I
18 started to get on a decent dose of injectable
19 estrogen where I started to reflected changes in my
20 blood work what I had been crying over and praying
21 for for years and the physical changes that started
22 to confirm to me that I was actually becoming the
23 person I always knew myself to be and maybe more
24 importantly that the incredibly unwelcomed advance of
25 masculine traits in myself began to cease. The

2 reason I bring all of this up is that trans people
3 are often incredibly afraid of losing quote/unquote
4 "really any more of our lives and time than we
5 already have." I really feel that we need to train
6 providers to not—treat fairly routine anxiety about
7 procedures and treatment. It's something to add
8 along the serving them. A lot of very real and
9 preventable harm is getting done when we do this.
10 Trans people are from part of the scare media before
11 transition especially we have these chances to live
12 our authentic lives and to meet other trans people to
13 help reassure us about every other thing that we need
14 to do to become our true selves. So, my last two
15 years that we've become—taken—that we take far more
16 seriously combatting this phantom boogieman, a non-
17 existent risk of trans in constant tiptoeing in case
18 trans patients do things like change their mind that
19 often comes from cis medical provider giving trans-
20 centered care. Providers need to be educated about
21 how to reassure their patients and the anxieties that
22 we have to have a more comprehensive idea of where we
23 are coming from when they administer treatment to us.
24 We need to stop treating provider wider needs about
25 things like prescribing too many hormones too fast.

2 That helps no one and hurts scores of trans patients.
3 I don't know about any trans patients who have
4 stories of regrets about taking too much of a dose of
5 HRT, but I do know many patients like myself who have
6 gone through ridiculous times when dealing with
7 apparently the most accepting and understanding
8 providers before getting appropriate doses they need
9 and medication. It is truly ridiculous and it does
10 need to stop. Below I've provided my email address
11 for you if you'd like to reach out and [bell] and
12 continue this conversation any time, and I appreciate
13 all of the time you've given to me. Thank you.
14 CHAIRPERSON LEVINE: Impeccably timed and
15 thank you for sharing your perspective Brianna, and
16 it's—it's very painful to hear about the challenges
17 you faced, and it should inspire all of us to make he
18 system do better for you and for many, many other New
19 Yorkers. Thank you for speaking out. Cecelia.
20 CECELIA GENTILE: Hi. So, Chair Levine,
21 Chair Rivera thank you so much for having me here.
22 My name is Cecilia Gentile, and I work—I've been
23 managing the Policy and Public Affairs at GMHC Gay
24 Men's Health Crisis, and a founding member of Equity
25 Coalition. Today I am here representing both, but

2 more interesting really as a person of trans
3 experience, a transgender woman that get sick
4 sometimes like anybody else. I have the privilege to
5 have a great insurance, and to be able to have a very
6 sensitive medical provider who offers me health
7 services crafted to my experience and understand my
8 body and my realities in life. But I also get sick
9 after 6:00 p.m. and I also get sick on the weekends.
10 For years I have experienced the most terrible
11 treatment at city hospitals from being misgendered to
12 being told by providers that they didn't know if they
13 could put me in a woman's room as if I wasn't one.
14 From being told by a doctor that they didn't want to
15 check my private parts because they didn't want me to
16 feel uncomfortable to having to explain to nurses why
17 I don't have a menstrual cycle. Very inconvenient
18 scenarios to experience in life and even worse while
19 be sick or unwell. The great city of New York offers
20 me the chance to make a complaint, and that is
21 reaffirming, but it is time to prevent this
22 interactions and experience them and then complain.
23 We do need to make services at city hospitals
24 comprehensive of people like me. How? We could
25 train medical providers and employers in generals—and

2 employees in general at city hospitals. We then
3 create a TGNCNB healthcare liaison program across
4 hospitals with transgender non-conforming and gender
5 non-binary staff assisting other members of the
6 community navigate health systems, and we can also
7 create a transgender non-conforming and gender non-
8 binary specific fair review board composed by
9 community members to oversee transgender non-
10 conforming and non-binary healthcare in public and
11 private healthcare systems. Thank you so much for
12 taking the opportunity and giving me the time to
13 talk. Here is my information and my email and my
14 phone is there, too.
15 CHAIRPERSON LEVINE: Thank you Cecelia
16 and for your ongoing amazing leadership in this work.
17 It's always wonderful to have your voice, and the
18 great Freddy.
19 Good afternoon. Thank you, Chairman
20 Levine and Chairman Rivera and the members of the
21 committee for the opportunity to speak this
22 afternoon. My name is Dr. Freddy Molano, and I'm the
23 Vice President for Infectious Diseases and Education
24 Programs at the Community Healthcare Network. CHN is
25 a fair and qualified health center that has 15

2 clinics including today's school based centers, and
3 it needs (sic) five more units. For nearly 15 years
4 CHS has provide affirmative healthcare services to
5 transgender and gender nonconforming individuals
6 throughout New York City in a family setting
7 environment. We serve approximately 500 transgender
8 and gender nonconforming individuals in our
9 Transgender Family program and our Sexual Behavioral
10 Health clinics based in Queens, the Lower East Side
11 and Queens and Manhattan. Our mission is grounded in
12 the belief that all the individuals have the right to
13 comprehensive and cultural responsive care. Part of
14 the mission is our direct to ensure that the TGNC
15 receive services in an environment that is both safe
16 and affirming. These include providing care at city
17 health centers and promoting changes across the large
18 healthcare system. However, many transgender TGNC
19 individuals continue to face challenges accessing
20 gendering affirming care. Among the larger barriers
21 to care are fears of accusations, making claims,
22 denials and a limited clinical workforce in the field
23 of trans health. We hear these challenges from the
24 patients, and are—and we're trying to work on ways to
25 overcome them. In many ways the path to TGNC

2 friendly healthcare begins outside the medical health
3 centers, to build better partnership between
4 providers and patients, commissions must come out of
5 the—to the table with better understanding of the
6 TGNC health concerns. Medical schools should
7 incorporate mandatory transgender health training in
8 the curricular and academic institutions should
9 prioritize research and transgender health
10 disparities and outcomes. These efforts should be
11 implemented along side with the development of better
12 metrics for measuring quality outcomes among the
13 transgender populations. These efforts should be
14 directed and included for transgender individuals.
15 Community Healthcare Network has already taken the
16 lead in building a clinic—a clinical workforce, and
17 this fall we hosted our—a conference on transgender—a
18 conference on transgender health that's we hope to
19 get more than 500 individuals to provide [bell]
20 expertise and I guess this is me. [laughs] Thank
21 you very much for having me—us in here. Thank you.
22 CHAIRPERSON LEVINE: Thank you, Freddy.
23 Thank you.
24 CHELSEA GOLDINGER: Hello. My name is
25 Chelsea Goldinger. I'm the Government Relations

2 Manager at the Lesbian, Gay, Bisexual, and
3 Transgender Community Center commonly referred to as
4 the Center. I just wanted to highlight some of the
5 TGNC support services we provide. I know that the
6 center's Gender Identity Project, which is our first.
7 TGNC is a big effort launched in 1989 as referenced
8 in the Committee Report and since then we have
9 expanded to other support services including
10 educational counseling, and specific career services
11 support and other economic stability initiatives in
12 that empowering the TGNC as we can do. In addition,
13 we actually on the insurance side we are a designated
14 navigator—navigator agency. So, we do help all folks
15 across the spectrum, and identity is actually
16 involved in New York State Health Insurance and on
17 the Exchange. So, thank you to both Council Members
18 River and Levine for, of course, convening this
19 hearing. We were—are continuing to be excited about
20 the city's LGBTQ Health Bill of rights, which as we
21 heard from the Administration earlier was a great
22 step. The problem we have heard from many of our
23 community Members is they're unaware of some of these
24 rights despite the fact that I know there have been
25 tremendous efforts to try and disseminate that

2 widely. Based on the feedback we have heard and
3 especially related to people reporting grievances, I
4 think that's the top concern that we have heard and
5 understand their rights, and that there was a method
6 for doing that. We do recommend the revamped
7 outreach effort to ensure that this goes across the
8 spectrum. For example I think elderly care and
9 family support care are often overlooked when
10 discussing TGNC health and I think that ensuring
11 providers like that and everyone who works in this
12 space at every level is well versed in affirming
13 supportive. The other area we wanted to talk about I
14 think what you've heard from others is care that not
15 specific to TGNC people to ensuring that that they
16 take care of those beyond this spectrum. Folks often
17 don't want to go to the doctor for checkups for basic
18 services, breast exams because for fear for not
19 having affirming care, and I think just ensuring that
20 we continue to talk about this section of health
21 heeds for the community. One of our biggest
22 recommendations that we have is to complement the
23 LGBTQ Bill of Rights to create an actual healthcare
24 toolkit specific—specifically—to do a healthcare
25 toolkit for healthcare providers. That actually

2 gives them guidance and tells them first things like
3 making affirming forums, verbal language to use as
4 affirming and supportive body language that's
5 supportive and something we heard from folks is that
6 there is one consolidate resource for providers to go
7 to as opposed to just kind of having a list of what
8 those rights are, but to actually enact those rights.
9 Regardless of any of these possible solutions, we
10 also just wanted to emphasize that TGNC are just New
11 Yorkers. They're not one monolithic group, and we
12 should look at them across identities. I was glad to
13 hear the question about ensuring services throughout
14 the five boroughs because that is something else we
15 have heard. People come to the center from all five
16 boroughs because of a lack of care within their own
17 boroughs and neighborhoods and so we'd love to see,
18 of course, more resources outside of our neighborhood
19 as well. Thank you and we'd be happy to partner on
20 any of these recommendations.
21 CHAIRPERSON LEVINE: Alright, thank you,
22 Chelsea. Go ahead, Council Member—Chair Rivera.
23 CHAIRPERSON RIVERA: Hi everyone. Thank
24 you so much and—and Freddy I know—I know you didn't
25 get to finish your testimony, but I saw something

2 here about your—the Tweet Program in Jamaica, Queens,
3 and linking people to HIV services.
4 DR. FREDDY MOLANO: Actually, I think the
5 program is set on gender, women of color enter in—in
6 and getting in care, and it was just declared by
7 HERSA as the evidence based science intervention. We
8 were able to recruit 186 women living with HIV, all
9 trans Latina mostly under Humantic (sic) and they
10 were—they go to us and been in care for five years,
11 and prior to by the law becoming something that
12 people talk about it, we were able to get a by the
13 law separation of 80%, and for the study that it last
14 five years. We were able to retain—have a retention
15 rate in 84% of those spaces. Right now, there's a
16 New York based evidence intervention. It's being
17 replicated in Puerto Rico, and Detroit, Michigan and
18 in New Orleans.
19 CHAIRPERSON RIVERA: And-and the reason
20 why I also mentioned it is because I had mentioned
21 earlier how with TGNC and the community it's
22 disproportionately homeless and unemployed and HIV
23 and AIDS is definitely and issue, and I wondered how
24 does that—how does that conversation influence your
25 work? How does it—how has it changed how you're

2 organizing and how you're speaking to people, and-and
3 when we talk about violence, and we mention 22
4 murders nationally--

5 DR. FREDDY MOLANO: Uh-hm.

6 CHAIRPERSON RIVERA: --but we know this is
7 an ongoing issue, and every trans remembrance week
8 there are more names to remember and to honor, and I
9 wonder how—how have these issues influenced your work
10 over the years, and—and that goes for anyone on the
11 panel.

12 DR. FREDDY MOLANO: I think the most
13 important thing is we are working with the trans
14 community. It is to ensure that we have—that we're
15 able to define what I call the Gate Keepers, the
16 leaders. We tried to go many times to academia, or
17 to more formalized education without thinking about
18 the better leaders in the community are the ones who
19 are now on the street who came to teach us, and in
20 bringing in the staff members. I think that that's
21 very, very important and also there were two
22 individuals before in here that I admire because
23 that's what they're preaching and they do every day,
24 which is Barbara and Nathan, and I think that when we
25 involve the community and when we work with them they

2 are able to get us where the resources are. They
3 know which housing unit has three places that I can
4 use tonight. They know which pantries I can bring
5 our patients today. So, don't be afraid of asking
6 the community what resources they have because they
7 are the best partners that we can have.
8 CECILIA GENTILE: And Ashe used to manage
9 a program at Becha (sic) that would complement
10 medical services with case management, and that was
11 great mortar, right because, you know, being—medical
12 services here, mental service—mental health services
13 in case management. So, it will give you a very free
14 wholly stake, you know, approach because it's not
15 just about like, you know, take your medicine. How
16 are you going to take your medicines if you slept
17 under a bridge, you know. It makes sense that you
18 may not remember to take your medicines, right. And
19 like it's—it's not—it's many other issues that—that
20 have to be taken under consideration when it comes to
21 healthcare. Unfortunately, it was just me and two
22 people for 625 patients, you know, and most of those
23 625 patients had extreme issues. It's like when you
24 stay in housing, it's like easy to get somebody
25 housing, right? When you stay in immigration status

like most of these and the people that I have helped, they had clear immigration situations for what they could, you know, ask for an asylum, or a TV or a U-Visa. It takes year to do that and three people could not take care of also so many people. That's why I believe like liaisons having liaisons in hospitals, having like, you know, patient navigators. Having, you know, case managers that help patients with other services that will complement. Their health is very, very important and, of course, those patient navigators or case managers, they have to replace them in the community. They should be transgender non-conforming or gender non-binary, too. Because it is my experience that me I don't open the same way to a case manager when it's cis gender than when it's transgender. I always like to see myself in the person giving me services.

CHAIRPERSON RIVERA: Thank you. Thank you very much.

CECILIA GENTILE: Thank you.

CHAIRPERSON LEVINE: A great panel. Thank you so much for all your work.

CECILIA GENTILE: Thank you.

2 CHAIRPERSON LEVINE: Next, we're going to
3 call up Andrea Bowen from the Bowen Public Affairs
4 Consulting Group; Vanessa Crespo from the New York
5 City Anti-Violence Project. [background comments,
6 pause] Tanya Asapansa and Jonathan Walker from the
7 New York Transgender Advocacy Group and Kiara St.
8 James also from the New York Transgender Advocacy
9 Group [background comments, pause] Welcome. Andrea,
10 do you want to start us off?
11 ANDREA BOWEN: Yes.
12 CHAIRPERSON LEVINE: Okay.
13 ANDREA BOWEN: Oh, I turned off the mic.
14 Good afternoon, Chair Levine and Chair Rivera, and
15 thank you both for holding this hearing. I am Andrea
16 Bowen. I'm principal of the Bowen Public Affairs
17 Consulting. I have the honor or consulting with New
18 York City Anti-Violence Project and also working in
19 coalition with several of the organizations that are
20 offering testimony today. Also, we're saying I'm a
21 trans woman, and I've been really delighted by your
22 questioning, and your deep focus on like really in
23 the-in the weeds issues here. So-so thank you, and
24 I'm also going to be submitting for the record, if
25 that's okay testimony of Jocelyn Costillo, a leader

2 and activist with Make the Road New York who wasn't
3 here to make it and her testimony is in Spanish so—I
4 want to reflect a couple of just reflections from the
5 community, and then just go into some quick policy
6 recommendations that you've heard already to day.
7 TGNC and BQ—and transgender non-conforming and non-
8 binary community members have said repeatedly in
9 public forums and otherwise that they face disrespect
10 and lack of knowledge about TGNC and be it health
11 issues from health providers across New York City. I
12 mean you've heard that, but it's just worth repeating
13 over and over and over again until it's just a
14 pattern on our brains. The second light, you know,
15 that extends not just to a lack of proper treatment
16 around TGNGNB specific healthcare, but also other
17 issues like heart disease, diabetes, just general
18 healthcare needs and so on. Third, community members
19 have spoke to the need for more widespread TGNC—
20 TGNCBB competent healthcare services across the city.
21 I know there is the discussion about the list of I
22 think over a 100 different places that people would
23 go for healthcare, but in—since 2015, Health and
24 Human Services studied that H&H cited a Mayor Report.
25 One of the findings out of that was that 24.2% of

2 TGNCNB reported facing long distances to receive
3 culturally competent healthcare compared with 11.1%
4 of people who didn't identify as TGNCNB. So, that's
5 worth noting. Generally, it might be located all
6 throughout the city, but that doesn't—that doesn't
7 necessarily mean it's where you need it to be, right.
8 So, finally a coalition of organizations I've worked
9 with including AVP, Sylvia Rivera Law Project, GMHC,
10 Make the Road New York and the Translator Mex Network
11 put forth policy recommendations a year ago that
12 could address some disparities for the community.
13 So, I'm just going to outline some of those. One
14 funding for community members especially TGNCNB
15 people of color to become a cadre of paid trainers
16 for medical assistance. You know, that solves two
17 problems, right and not only helps build a system for
18 training continuously, but also provides perhaps
19 employment for folks who are doing that kind of work.
20 Secondly, creating as folks have noted the TGNCNB
21 Healthcare Liaison Program across with TGNCNB people
22 as those liaisons to help people navigate the
23 complexities of the healthcare system, everything
24 from ensuring culturally competent care to making
25 sure insurance based treatments, and finally,

2 creating TGNCNB specific care review boards composed
3 of community members to oversee community healthcare
4 and public and private healthcare systems. So,
5 review boards, liaisons, a cadre of trainers all of
6 those staffed with actual TGNCNB people specifically
7 and I'm happy to detail these more at your request.
8 Thank you so much for this hearing, and I yield my
9 time.
10 CHAIRPERSON LEVINE: Thank you. All
11 three seconds of it. That was [bell] very important
12 and powerful remarks. Thank you, and you submitted
13 that in writing as well we believe. Is that right?
14 ANDREA BOWEN: Uh-hm.
15 CHAIRPERSON LEVINE: Look forward to
16 reviewing your policy proposals.
17 ANDREA BOWEN: Yeah.
18 CHAIRPERSON LEVINE: Thank you. Please.
19 VANESSA VICTORIA CRESPO: Hi. So,
20 greetings to the Committee on Hospitals and the
21 Committee on Health, and both Committee Chairs
22 Carlina Rivera and Mark Levine for hearing my
23 testimony of TGNCNB folks' access to services. My
24 name is Vanessa Victoria Crespo. I am a Client
25 Advocacy Specialist and Counselor at the New York

2 City Anti-Violence Project. As you may know, AVP
3 empowers LGBTQ and HIV affected communities and
4 allies to end all forms of violence through
5 organizing, education and supports survivors through
6 counseling and advocacy, and we envision a world in
7 which all Lesbian, Gay, Bisexual, Transgender, Queer,
8 HIV affected people are safe and respected and live
9 free from violence. I am here today because I'm-I'm
10 having access to proper and affordable healthcare is
11 something very important to me as a trans woman but
12 it's also paramount to the TGNC clients that we serve
13 at AVP. Thanks to the NYC's Transgender Rights Law
14 NCCHR Gender Identify and Gender Expression's legal
15 Enforcement Guidance, providers have been required to
16 improve their coverage for trans care even though
17 they still make trans folks jump through many hoops
18 and undergo headaches to get services they need. But
19 still many healthcare practitioners lack the
20 competency and care and to give us the care that we
21 need. In many instances, medical providers ask
22 intruding questions, and medical that are not
23 pertinent to the pressing health issues that we may
24 be experiencing. For example, I have clients at AVP
25 that share with me how they would go to a hospital or

2 urgent care for a cold or a flu, and have nurses or
3 doctors ask questions about their genitals or what
4 surgeries they have had, and even questions about how
5 their family members feel about their transition.
6 This is systemic violence that we know is affecting
7 TGNC people. For TGNC people knowing that these
8 questions are coming their way, it pushes them to
9 delay seeking the care that they need often further
10 escalating health issues that could have been
11 addressed before. It is important to note that
12 competent care is not just necessary for their
13 practitioner, but should be required for all staff.
14 Administrators, doctors, nurses and facilitate staff
15 should undergo trans competency training. Many
16 organizations including AVP already have existing
17 training [bell] that could be used throughout the
18 city and it is important to have city and TGNC
19 liaisons at every city hospital to help TGNC folks
20 navigate the healthcare system. We've been pushing
21 as a budgetary strategy with the TGNC Solutions
22 Coalition since last spring. It is pivotal—pivotal
23 for all healthcare providers to get the proper
24 education and training so that trans people can get
25 the safe and competent care that they need, and don't

2 need to turn to black market if not only for trans
3 healthcare being so expensive, but not to have to
4 deal shaming experiences with medical providers.
5 Thank you to the Committee on Hospitals and Health
6 and taking your time to hearing my testimony today.
7 CHAIRPERSON LEVINE: Thank you. Please.
8 Thomas.
9 KIARA ST. JAMES: Greetings. I'm going
10 to send—because I have a lot of typos on my paper.
11 So I'm going to send this to you all later on. So,
12 my name is Kiara St. James. I'm a black woman of
13 trans experience, and I know first hand how
14 discrimination has impacted my community especially
15 the healthcare system. This is one of the reasons
16 why I founded—I co-founded a non-profit organization
17 New York Transgender Advocacy Group, which I am now
18 Executive Director along with my co-founder Tanya
19 Asapansa-Walker. At NYTAG we focus on policies that
20 will help best serve the transgender and gender non-
21 conforming community. We also educate health
22 providers on TGNC issues and how to best serve or
23 community. This is because many members of the TGNC
24 community—in the community—in the TGNC community
25 including myself have shared horrific experiences of

2 being denied quality services. As recently as last
3 week, a colleague of mine was intentionally
4 misgendered at a very well known hospital in the
5 city. Another colleague and she—she is going to go
6 more in detail about that—also experienced
7 discrimination. WE must also remember housing is a
8 healthcare issue, and too many TGNC community members
9 are blatantly discriminated against even if they had
10 a city voucher that covers all their rent.
11 Therefore, I am here today to request mandated
12 ongoing transgender and gender non-conforming
13 sensitivity trainings to all medical providers and
14 their—and their supporting staff as well as security,
15 maintenance and other businesses that can conduct any
16 businesses with these medical facilities. Also, a
17 monitoring system to be implemented to penalize
18 landlords who continue to discriminate. Thank you.
19 CHAIRPERSON LEVINE: Thank you very much.
20 KIARA ST. JAMES: I'll accede my time.
21 TANYA ASAPANSA WALKER: Yes. Hi. I'm
22 Tanya Asapansa Johnson Walker, and the reason why I
23 use that name is my—it was my grandfather's name. He
24 was the first black fire chaplain in New York City
25 and they co-named a street after him on Staten

2 Island. I'm 55 years old. I am the Co-founder of New
3 York Transgender Advocacy Group, and I'm the Policy
4 Liaison there. In 2017—I have it written here—I came
5 down with lung cancer again for the second time in
6 March of that year, and while I was at the hospital,
7 I was misgendered constantly by the staff, even the
8 social worker, and I was left in diarrhea, and I was
9 also—I had to clean my room by myself. The staff was
10 very disrespectful. I was harassed. I was
11 mistreated. I was treated like a dog. I'm an Army
12 veteran with an honorable discharge, and the staff
13 there at Memorial Sloan Kettering they didn't have
14 and LGBT program for us to go to, you know, or
15 somebody to help us that was LGBT at the hospital
16 although they say they're LGBT affirming. See, what
17 it is, they get lost, everyone gets lost in the
18 alphabet the LGBTQ, but no, I'm transgender and
19 transgender people are always eliminated from that
20 alphabet, and while I was at the hospital I mean I
21 had catheters shoved into me into my urethra and I
22 bled. I-I had to clean my own room with one arm
23 dragging a tank an oxygen tank and a—one of those
24 urinal things that you urinate in. It was a big
25 plastic can, and I also had a pump on a pole that I

2 had to drag around cleaning my room. I was refused
3 my medications, and when nurses were talking about me
4 in the room, they were misgendering me as well. The
5 social workers--I have their names and everything—
6 told she doesn't have to call me by my gender
7 pronoun. She says she calls me as what she sees me
8 as. I mean the training must be done by transgender
9 women. We're discriminated against the most. We're
10 all constantly misgendered by staff at the hospitals
11 even today. You know, I've been refused dental
12 treatment at Harlem Hospital, you know, and
13 misgendered. I mean breach of confidentiality
14 constantly. I mean they feel like they have the
15 right to discriminate against us, and when I tried to
16 get help from a lawyer or the Human Right Commission,
17 [bell] they told me that they could not help me.
18 They couldn't promise they could help me. So, that's
19 why there's not that many lawsuits going around
20 against these hospitals because we are being refused
21 help. Thank you.
22 CHAIRPERSON LEVINE: Well, thank you Ms.
23 Asapansa Johnson Walker. Thank you for you service--
24 TANYA ASAPANSA WALKER: [interposing]
25 Thank you.

CHAIRPERSON LEVINE: --to the nation. It's horrifying to hear what you have been subjected, but Anthony described it as MSK. Was that recently or was it--

TANYA ASAPANSA WALKER: That was in 2017. That was my second time with lung cancer.

CHAIRPERSON LEVINE: Okay and has the hospital given you any kind of response? You filed a complaint.

TANYA ASAPANSA WALKER: No, that—I had a letter sent. I had it written by Sylvia Rivera Law Project. They haven't written me back, and I called Dr. Downey's Office the other day, and they told me that my account was blocked. So they didn't—they're refusing to treat me now because I had a letter written.

CHAIRPERSON LEVINE: Okay, well maybe the Chair and I will follow up directly with the hospital and you mentioned you were denied dental care. Was that at Harlem Hospital?

TANYA ASAPANSA WALKER: That was at Harlem Hospital. I was denied dental care.

2 CHAIRPERSON LEVINE: All the grounds that
3 they claimed they're not equipped to deal with
4 transgender people?
5 TANYA ASAPANSA WALKER: On-on different
6 health issues. They-they were like asking me for
7 information I didn't have, you know, to—and refusing
8 to do it. This is before I went to Israel in June.
9 CHAIRPERSON LEVINE: Okay, if it would be
10 helpful, I know that we would be happy to follow up
11 on that matter as well. Are you currently—we could
12 talk at another time, but if you're not currently
13 getting adequate care and anyone in the Council can
14 help with that. We would, of course, be very happy
15 to fight for you in any way.
16 TANYA ASAPANSA WALKER: Thank you.
17 CHAIRPERSON LEVINE: Yes.
18 TANYA ASAPANSA WALKER: Thank you.
19 CHAIRPERSON RIVERA: Yes. Clearly you're
20 someone who's empowered and you know you can got
21 places. So, I can just imagine all the stories that
22 aren't told. So, I just want to thank you for sharing
23 your experience, which is actually a big deal, and
24 anyone in this room or anyone that you know, if they
25 experience something like that in a place that is

2 supposed welcome every single person that walks
3 through that door, please let us know.
4 CHAIRPERSON LEVINE: And Ms. St. James
5 will you-
6 CHAIRPERSON RIVERA: [interposing] Thank
7 you for your service.
8 TANYA ASAPANSA WALKER: Oh thank you.
9 Thank you.
10 CHAIRPERSON LEVINE: Ms. St. James, well,
11 you—you mentioned that the organization is doing some
12 training of medical professionals. Is it appropriate
13 for you to tell us where are you doing that training,
14 what kind of hospitals or settings?
15 KIARA ST. JAMES: Yes. So, we do
16 trainings. Currently, we're located in Harlem, 125th
17 215, second floor.
18 CHAIRPERSON LEVINE: [off mic] Where is
19 it?
20 KIARA ST. JAMES: So, West 125th Street.
21 Thank you. So, we do training. So, we actually just
22 had here—actually, we had a series of six-hour
23 trainings where we had people RSVP. So, they come
24 into our—our setting. So, we share a space also with
25 Emblaca (sic). Right. So, we have a space on the

2 third floor where we can do our day [coughs]
3 trainings. So, in those trainings we talk about the
4 micro, meso and macro levels of advocacy. Also,
5 because I was in NEPA. He was in NEPA before me, but
6 it was cool. So, that's a peep of municipal
7 involvement people living with—with AIDS. As someone
8 who has been HIV empowered for over 20 years we lead
9 with lens in the work we do, and so, it's been a
10 turnout. You know, talking about issues that have
11 impacted the trans community. We also had an amazing
12 turnout for the first ever trans sponsored by New
13 York Trans Gender Advocacy Group Policy Day in Albany
14 where we address our legislative platform, which
15 consists of gender, conversion therapy. What is the
16 other? Comprehensive healthcare starting in
17 elementary school as well as gay--
18 TANYA ASAPANSA WALKER: [interposing] And
19 trans.
20 KIARA ST. JAMES: --transpanic. Thank
21 you, and so we do a lot. We encompass a lot of that
22 work and how we are really making sure that we are
23 not just meeting with medical providers, but also
24 educating our community members. We're very boots
25

2 one the ground, and so we take that very
3 passionately.
4 CHAIRPERSON LEVINE: Well, thank you.
5 What an incredible panel from start to finish. Thank
6 you all for speaking out today. And our final panel
7 I Noel Lewis from Transgen—Transgender Legal; Sasha
8 Alexander from the Sylvia Rivera Law Project; and
9 Carrie Davis. Noel, would you like kick us off?
10 NOEL LEWIS: Sure. I'm Noel Lewis the
11 Intern and Senior Staff Attorney at Transgender Legal
12 Defense Education Fund. I'm also the Executive
13 Director of Transgender Legal, which is an
14 organization that focuses on challenging insurance
15 denials and exclusions for transgender people. So, I
16 wanted to share with you some stories of provider
17 discrimination as well as insurance discrimination
18 from people in New York City. So, in July somebody
19 contacted us, the sister of a transgender man who
20 suffers from anxiety and depression and he had worked
21 up the courage to go to a gynecologist so he could
22 have a hysterectomy, and he did not want to travel.
23 He could not—was not able to travel far to Manhattan
24 to come to a provider who specializes in transgender
25 care. So, he called around to a lot of local

2 providers in Brooklyn. Most of them simply didn't
3 return his phone call, but one of them did. So, he
4 went and he had an appointment, and they hysterectomy
5 was to be scheduled, but the woman who was going to
6 schedule it simply laughed at him, and the doctor did
7 not address this issue, and he was supposed to have
8 another procedure done and, and he cancelled that.
9 He hasn't gone back to the doctor, and now he's
10 afraid to go to any doctor, which is just emblematic
11 of the kind of discrimination that transgender people
12 face. Similarly, a transgender man went to Mount
13 Sinai to have a hysterectomy where they do have
14 someone who is—does specialize in hysterectomies for
15 transgender men, but the staff has not all been
16 changed as was indicated, and so he was being
17 misgendered, and at the time he was also experiencing
18 complications from the hysterectomy, and it was a
19 very distressing time for him to be misgendered in
20 the hospital like that. Another issue, which has
21 come up is that midwives in New York State are only
22 licensed to treat women under the law, and so a
23 transgender woman went to a private clinic, and when
24 she was asked when her last menstrual cycle was, and
25 she explained she didn't have one because she was

2 transgender, the person oh, I'm not licensed to treat
3 men, and went out and checked with her supervisor,
4 and came back and, you know, without doing any kind
5 of questioning about her surgical size or anything
6 like that, you know, it was just like I can't treat
7 you because you're a male. So, she was misgendered
8 in ways so that she couldn't even access care from
9 this person. And on the insurance front, there are
10 barriers that come from the insurance companies. So,
11 even city of New York employees they—if they have a
12 GHI plan, which is administered by Emblem Health,
13 their policy, their clinical policy on under their
14 affirming care categorically states that certain
15 treatments such as facial permenization (sic) or
16 voice therapies are considered cosmetic and they
17 place an extra burden on transgender people to
18 overcome that to get covered. So, what we think is
19 helpful is funding for training at these hospitals.
20 I was one of the people that is doing the training at
21 HH Hospitals for the adolescent providers, and it is
22 very effective to be able to get in there and-and
23 train the people. Another thing that's very
24 effective is medical legal partnerships. When people
25 are getting insurance denials, they are generally

2 effective if the person has legal representation. If
3 they have access to counsel, they can get those
4 insurance denials overturned but there's a question
5 of resources right now. People don't have enough
6 access to attorneys, and finally enforcement by the
7 New York City Human Right Commission so that—so that
8 people don't have an attorney because, you know, the
9 person in Brooklyn getting misgendered, a private
10 attorney is not going to be able to take that case.
11 There's not enough money there, but it would be very
12 effective for something like the City Human Right
13 Commission to dome in and take an interest that they—
14 even getting intake it can take months. There. It's
15 just wildly under-resourced. [bell] Thank you.
16 CHAIRPERSON LEVINE: Thank you very much.
17 Now, we're going to have the one Sasha.
18 SASHA ALEXANDER: Hi. Good afternoon, and
19 I appreciate you holding this hearing because often
20 as organizers we feel like we're the ones beating
21 down the door to get to you all in the room with us.
22 So, it's nice to be invited to the room to be here
23 with you all. I'm Sasha Alexander. I'm the Director
24 of Membership with Sylvia Rivera Law Project. We
25 fought for healthcare and numerous other issues for

2 TGNC folks for over 16 years, and about two weeks ago
3 leading up to this hearing we held a listening
4 session to talk to some of our members about the
5 issues, and before I go into those, I want to thank
6 you for highlighting the intersection with Trans Day
7 of Remembrance and also highlight that those numbers
8 don't include trans people who were harmed by the
9 medical/industrial complex of suicide, and so there's
10 so much intersection in people being able to access
11 healthcare and that actually leading to a number of
12 deaths in our community. So I appreciate you all
13 making those important connections. So, in the
14 listening sessions we held, people talked about
15 providers, insurance companies, pharmacies and
16 hospitals' access to hormone specifically
17 testosterone and estrogen, detours and potholes on
18 the way to receiving care such as healthcare
19 professionals not providing affirming care. We agree
20 that you have to fight to get access and share that
21 you had to deal with denials of care alone or felt
22 that your provider wasn't listening when you
23 expressed how much anxiety that created. One woman
24 was even told she wasn't ready, and was told what she
25 needed for her body, and she had expressed what she

2 needed for years. A lot of folks share their
3 experience with doctors and nurses not wanting to
4 touch them, and everyone agreed ERs and psyche units
5 needed better training to work with TGNC people. So,
6 I'm here to share a little more about some of those
7 areas both on behalf of the themes that we've seen in
8 our membership and as a trans person myself who
9 accessed care for over 15 years. So, one of the
10 issues that I named was access to surgery and
11 hormones, and I think it's already been named. It is
12 a huge issue with denials that folks are going
13 through, but while that's happening, that can send
14 someone spiraling into crisis not only having to
15 repeatedly get denied and with what that can bring up
16 for them, but also then having to wait and wait and
17 not necessarily be able to access that care. And so
18 we've also talked to one of the community members who
19 were isolated after they accessed care and did not
20 have the quality of the results that they wanted
21 whether they felt those results ware botched or those
22 results needed multiple-multiple revisions. There
23 was a lot of isolation particularly for trans women
24 who experienced this, and our members are folks who
25 are low-income. They're people living with HIV.

2 They're immigrants. They're folks with disabilities
3 and there are a lot of folks who don't necessarily
4 feel they can go to or have felt it's been effective
5 to go to the Commission on Human Rights ourselves.
6 We are a legal service provider, and now we're
7 eliminated because a lot of these are cases that our
8 folks cannot—cannot take. There's also the issue of
9 actually after people have surgery and they go to a
10 public hospital. We had one member—this was about
11 two years ago who bled out in Harlem Hospital [bell].
12 She's alive but she had a terrible experience with
13 care there. I just want to highlight a couple other
14 pieces. Mental health support has been a huge issue
15 for us folks. So, obviously folks have to access
16 mental health support to gain access to surgery, but
17 there's not enough consistent resources for folks
18 whether there's a certain number of mental health
19 sessions they can have or not having people with
20 color or trans folks who can provide that care for
21 them. The other issue is staffing, which I feel like
22 folks have talked about, but one issue specifically
23 was feeling that there are not enough surgeons to
24 provide the procedures that folks want and now that
25 there are the long wait list or concerns about for

2 example the surgeon at HHC for example who's only
3 done 20 surgeries in the years they provided surgery
4 versus the other more population places our community
5 goes. There's a definite need for advocacy support.
6 When you're in these facilities you shouldn't need it
7 as folks named were part of this TGNC Solutions
8 Coalition, and we know how important it is for folks
9 to have navigators and advocates in those spaces like
10 Sarah Benders all over the place. Even if she's very
11 effective, people don't know she exists or don't know
12 about that resource and we've worked with her
13 directly and heard that they don't have the funding
14 to let people know about their services, which is a
15 huge issue, and the last one that I just want to
16 name, which is a really important issue to us and
17 people that have named homeless communities is that
18 if you are in a DHS Shelter, you cannot access
19 surgery and so we have TGNC folks who have been the
20 shelter system 3—going on 3 years and they have had
21 to wait to access their care because they cannot
22 access it. We've sat down with DHS to talk about
23 this issue. They have told us they're not a medical
24 care provider. They don't have to meet those needs.
25 We even had a member who needed a knee surgery. She

2 had to wait two years to have that so she could get
3 housed. So, there's a real important issue because so
4 many of our folks are pushed out of homes and into
5 the shelter system, and then many of our folks don't
6 feel safe to stay in the shelter system that they're
7 just not able to access surgery as a result, and
8 that's like I said before sending a lot of folks
9 spiraling in terms of that. So, I would just push
10 for what a lot of folks have already asked for in
11 terms of more TGNCs specific advocates and supports.
12 The other one is connecting to the shelter system is
13 TGNC specific hallways or spaces where folks can
14 receive their care and the other one, which someone
15 named is Substance Abuse Centers that are specific to
16 TGNC folks. Thank you.
17 CHAIRPERSON LEVINE: Thank you, Sasha.
18 Carrie.
19 CARRIE DAVIS: Good afternoon and thank
20 you for this opportunity to talk about the health
21 needs of transgender and gender non-binary people.
22 My name is Carrie Davis. I'm a Healthcare Consultant
23 and Trainer and I serve as the New York State
24 Commission on Human Rights. So, I want to hear more
25 about some the incidents, and the incidents, and I

2 worked at Vail (sic) Community Center for 13—for 18
3 years. It’s well documented that trans people are
4 more likely to experience significant health
5 disparities compared to their counterparts. Of all
6 these concerns, the disparity concern of HIV always
7 attracts the most attention and for good reason.
8 Trans women in particular trans women of color are
9 the highest HIV risk group in New York City and the
10 world, and HIV had become a seductive but selective
11 framework for trans health. Trans people are
12 described as high risk and our healthcare is reduced
13 to HIV hormones and surgery usually in that order but
14 trans people know this is not a substitute for
15 genuine healthcare. Most importantly, HIV is often
16 not a high on the list of needs prioritized by our
17 community. When asked about healthcare, trans New
18 Yorkers speak of unemployment, homelessness,
19 immigration, access to, denials of and lack of
20 healthcare choice, violence, criminalization and
21 incarceration. We speak of being desperately poor
22 and almost twice as likely to be of very low income.
23 Latin American, Trans Activist Marcela Romero noted:
24 I’m not a high risk person. I’m a member of the
25 community that’s put at high risk. We must address

2 the forces that place trans people at health risk to
3 improve the health outcomes of trans New Yorkers.
4 The social improvements of trans health should be our
5 focus. That sounds daunting but we can do this. The
6 majority of resources required to comprehensively
7 address the health concerns of trans New Yorker
8 already exists, but are often for a variety of
9 reasons in accessible to us. Trans health is not
10 only a matter of HIV, hormones and surgery. It's not
11 a matter for hospitals, community health centers of
12 the Department of Health. It's a matter of policing,
13 corrections, education, employment, housing,
14 immigration, youth and more. We should be hearing
15 from DOE, NYPD, HRA, DHS, ACS, DOC and others at this
16 hearing today. We should be building a comprehensive
17 and holistic network of strategic private and public
18 partners who worked together to leverage New York's
19 strengths in order to improve socio-economic and
20 health outcomes. We should build an approach that
21 recognized the trans and poor are served by a wide
22 base of service providers that rather than a single
23 organization. We should build an approach that
24 recognizes that trans live in all five boroughs, in
25 all communities that cannot be served by a few

2 centers of excellence. We should recognize—we should
3 promote a transgender health network. This could
4 consist of three basic components, a network of
5 linked resources and provide—and qualified providers
6 a road map with guides and navigators to ensure trans
7 people can access the network, and public leadership
8 to bring these partners together and measure
9 outcomes. A lot has happened in over 20 years since
10 I began working in the field of trans health. There
11 have been some successes, but we still struggle in
12 ways we had hoped would become part of our history by
13 now. [bell] Something has to change if trans New
14 Yorkers are to take their rightful place as whole,
15 healthy, successful and self-sufficient leaders. We
16 can start by retooling our work towards the outcomes
17 that trans people themselves prioritize where there's
18 been those decided by—for them by others with
19 different agendas. If trans people and 52 (sic) are
20 trans people of color are identified and engaged in a
21 network of trans led and relevant support services
22 that directly improves our economic, education,
23 social and health status, we will be healthier and
24 more likely can make a successful transition to self-
25 sufficiency. We will become change agents and

2 contributors to a healthy and thriving New York
3 community. Addressing these concerns for transgender
4 people are sustainable and cost-effective and will
5 reduce the negative health consequences such as HIV,
6 suicide, homelessness, incarceration as well as their
7 as their associated costs. Thank you.
8 CHAIRPERSON LEVINE: My goodness. I don't
9 know if you agree, Madam Co-Chair, but the testimony
10 in this hearing from start to finish to finish has
11 just been incredible and so on point and powerful
12 including this panel here. It's great that this is
13 all being archived. The video will be available
14 probably in the next day or so for the public to
15 review and all of your testimony is going to be
16 transcribed as well in addition to what's entered
17 into the record. So, we need to make sure that the
18 broader hears some of the very powerful testimony
19 that all of you offered. I just want to ask one
20 question about this topic that's come up again and
21 again and again with the Human Right Commission,
22 which is the question of whether and when a report is
23 a made of someone discriminating in the healthcare
24 context against a trans New Yorker or gender non-
25 conforming and non-binary New Yorker. Is there any

2 sanction or enforcement or any punishment meted out
3 in response to what are clear violations of the law?
4 Or in your experience does the complaint just sort of
5 die after it's registered?

6 CARRIE DAVIS: I was just going to say
7 that all people we've worked with who we've seen
8 complaints investigated, none of them at least that I
9 can think of right now are actually specific to the
10 healthcare setting, and I don't know you-

11 NOEL LEWIS: One issue is that this is—
12 can't be addressed in the moment. So, if somebody is
13 in a hospital, if they're in a hospital because
14 they're suicidal and they're being misgendered,
15 that's a situation that needs to be remedied right
16 the, and so the Commission can't necessarily do that.

17 SASHA ALEXANDER: Yeah, I would say that
18 if you have to go to the Commission on Human Rights
19 to get your needs met, our system has failed. I
20 have—I have been thrown out of businesses in New York
21 City as a transgender person when I tried to change
22 on clothes. Now, this was years ago, but I didn't go
23 to the Commission on Human Rights to press a
24 complaint because that's a really horrific
25 experience. It's humiliating, it's degrading, and to

2 go through the process of seeking assistance whether
3 it's with a private attorney or an advocacy
4 organization like SRLP or the Commission on Human
5 Rights, requires someone to have a tremendous power
6 and courage, and be willing to be re-traumatized.
7 The Commission I think does its best. It had its
8 budget cut this year, and when we're talking about—
9 about why—why is this—why is this Commission on Human
10 Rights not as effective as it could be. I think we
11 need to look at-at the city and how it treats the
12 Commission on Human Rights, but I do think that
13 there's a lot of—the Commission is made mostly of
14 lawyers who investigate cases and try to make
15 successful outcomes from those cases when they can do
16 so. I think their hearts are in the right place.
17 CHAIRPERSON LEVINE: [interposing] Sorry
18 to interrupt you. you said that the Commission had
19 its budget cut because we just increased the staffing
20 there last year.
21 SASHA ALEXANDER: It had its
22 administrative budget cut.
23 CHAIRPERSON LEVINE: The what?
24 SASHA ALEXANDER: It had its
25 administrative budget cut. So, you're basically

2 saying he—we're increasing part of your budget, but
3 the part that makes you able to function, which is—
4 imagine how you could work without your aids and
5 assistants here at the Council.
6 CHAIRPERSON LEVINE: So, the overall
7 budget has been increased, but the administrative
8 piece was reduced? Is that right?
9 SASHA ALEXANDER: Yes, it's cut
10 significantly. So, I think what we see is that we
11 have to really look at ourselves as—as a city and how
12 we—what—what really—real outcomes. We the Commission
13 of Rights to be effective. We are going to invest in
14 it.
15 CHAIRPERSON RIVERA: So, we've talked a
16 lot today of individuals who are TGNCNB with
17 intersecting identities, and so, I wanted to ask what
18 can we do to better assist specifically the disabled
19 community, New Yorkers that are differently abled
20 specifically New Yorkers with disabilities, just
21 based on your experience.
22 CARRIE DAVIS: Well, specifically like
23 the in the shelter system like we talked about?
24 CHAIRPERSON RIVERA: Yeah, there's—and I
25 agree that this has to be a holistic

2 CARRIE DAVIS: [interposing] Yeah.
3 CHAIRPERSON RIVERA: --approach and—and we
4 didn't talk a lot about the shelter system, though I
5 really would like to. I just know that H&H will say
6 okay, you know and I had this conversation with
7 Commissioner Banks about we talk about homelessness
8 and when I bring up supportive housing they're like
9 oh we don't do supportive housing. So, I just wonder
10 but you provide wraparound services. You know, so
11 there is a—a disconnect and it has to do with
12 bureaucracy and inefficiency and we have a long way
13 to go as a city. I just wonder in some of the—maybe
14 the testimony that you've heard from some of the
15 people—from some of their experiences, you know, that
16 the dis—the disability community and how they access
17 healthcare is extremely troubling, and so I just, you
18 know, I know you've made a number of recommendations,
19 but if you have some specifically for New Yorkers
20 with disabilities we are—are very welcome to seeing
21 how we can implement that at the very least in how
22 you access healthcare. So, just something to think
23 about.
24 CARRIE DAVIS: I mean I know one—one part
25 of that is people physically being able to access it

2 and there have been concerns around Access-A-Ride and
3 different pieces like that. I know there are some
4 TGNCNB who have had issues, who have Access-A-Ride.
5 Whether that's being misgendered or mispronounced.
6 They're the same things we see in every system. I
7 think a lot of the things that happen to TGNC folks
8 who are disabled they're not unique to be BTGNC like
9 a lot of the intersections that we have, but I think—
10 I think overall in terms of being able to access care
11 like folks named like specialty services or like if
12 you're being referred to services there are a lot of
13 issues. So, I—I know we've heard from folks who are
14 disabled like when they going to their specific
15 provider it's obviously not a Callan Board or an
16 aperture or something like that, but they might be
17 that experiencing. Like if they're non-binary being
18 misgendered or being misnamed even if they've had
19 their name changed.
20 CHAIRPERSON RIVERA: Thank you.
21 NOEL LEWIS: Could I—could I just raise
22 and related to that a lot of discussion today has
23 been about training and I think we need to see
24 medical facilities incorporate the needs for
25 transgender people or disabled people or disabled

2 transgender people as part as their DNA. It
3 shouldn't be coming from an outside advocacy group.
4 I used to train with the New York City Police
5 Department for the NYPD, and as an outsider I'm not
6 seen in a favorable light. The NYPD is much more
7 productive when it brings—when it has transgender
8 cops doing those trainings, and I think that the
9 hospital system should be having transgender staff
10 helping them moderate a training process. I'm not
11 suggesting you bringing, you have your own staff,
12 doctors training doing basic diversity or sensitivity
13 trainings, but I am saying that internally these
14 organizations bring in outsiders and the staff always
15 see this as an outside issue. It has to become as I
16 said kind of part of their DNA, and so everyone likes
17 to be trained by the profession that they belong to.
18 Doctors like to be trained by doctors, social workers
19 by social workers and so forth. These systems have
20 to bring this internally in a way that they can see
21 this as their issue and not some other force pushing
22 back at them.
23 SASHA ALEXANDER: Actually one more thing
24 that I just thought of in terms of disabled folks in
25 terms of being able to access hormones or surgery

2 there is something in the—in the Wpath Standards that
3 a lot of people use to determine care about pre-
4 existing mental health conditions. Sometimes being
5 used as a reason to not allow somebody to have access
6 to care. So, for example like we've have—we has a
7 member who was Schizophrenic. He's a trans man. He
8 was undocumented and he tried for three years to get
9 hormones and his provider wouldn't prescribe him
10 hormones because the provider felt that he because of
11 his diagnosis wasn't actually trans. He just wasn't
12 sure about his gender certain days, and so I think
13 there's doubly intersections there that there needs
14 to be more not just training. Ideally I think by
15 disabled TGNC folks who have—who have been left out
16 of some of the discussion about that, but to be able
17 to bring that to folks.
18 CHAIRPERSON RIVERA: Thank you. Thank you
19 for your contributions, and I want to thank everyone
20 for their patience as well today and the length of
21 the hearing. So, thank you. Thank you both.
22 CHAIRPERSON LEVINE: Okay, this concludes
23 our hearing. Thank you all very much. [gavel]
24 [background comments, pause]
25

<u>C E R T I F I C A T E</u>

World Wide Dictation certifies that the foregoing transcript is a true and accurate record of the proceedings. We further certify that there is no relation to any of the parties to this action by blood or marriage, and that there is interest in the outcome of this matter.

Date <u>December 13, 2018</u>