City Council Budget Hearing

Testimony by Chief Medical Examiner Dr. Barbara Sampson

Fiscal Year 2016

Good morning Chairman Johnson and members of the Health Committee. Thank you for the opportunity to testify.

I am Dr. Barbara Sampson and am proud to be sitting before you today as the appointed Chief Medical Examiner of the City of New York. I have a clear mandate from the administration to lead the medical examiner's office to protect the public health and serve criminal justice through forensic science. My personal commitment to this city is to build our medical examiner's office into the model for what the National Academy of Sciences defines as the ideal forensic institution: independent, unbiased, immune from undue influence, and as accurate as is humanly possible.

Seated with me are Dina Maniotis, Executive Deputy Commissioner for Administration, Florence Hutner, General Counsel and Frank DePaolo, Assistant Commissioner of Forensic Operations.

My entire OCME team and I want to recognize the support of our Deputy Mayor Dr. Lilliam Barrios-Paoli and OMB for the fair and considered funding of our most urgent needs. I am here today to discuss the Fiscal Year 2016 Preliminary Budget for the Office of the Chief Medical Examiner, but first I would like to update you on key agency initiatives and progress.

As you know, the OCME's Department of Forensic Biology serves as the forensic DNA laboratory for the City of New York. The OCME houses North America's largest public and most advanced forensic DNA

laboratory, and is a leader in DNA technology and research. We are continuing to work on the unidentified remains from the 9/11 attack on the World Trade Center. In 2014 we identified three previously unknown individuals, and in 2015 we have already identified one. We have also re-associated many remains to previously identified victims.

The Department of Forensic Biology is in its second year of transformation using business improvement tools. To date, the laboratory has been redesigned from a system where three, essentially self-contained, silos existed to one where everyone participates in six-person work teams to examine 40 criminal cases in a strict ten-day process. Casework is now flowing efficiently through the laboratory. Our success has been possible due to last year's funding package that augmented the Lean Six Sigma business improvement plan. We were funded to hire 16 new criminalists and since July 1, 2014, the department has hired these sixteen new employees and also promoted 54 employees into more senior criminalist titles. This is a rigorous process. Every new hire and every promotion requires an intensive three-month training program.

The Department of Forensic Biology received 8,746 cases in 2014. Of that total, 1,940 cases were very violent felonies including assaults, sexual assaults and homicides. Currently, the laboratory has no backlog in homicides and sexual assault cases. In other words, within days of receipt, the lab scientists start those cases and a case report is sent to NYPD and the appropriate District Attorney Office within two-three weeks.

While it is common knowledge that DNA can be used to identify individuals, there are occasions where DNA is not an option due to natural or intentional DNA degradation. Currently individual identification is not possible in such cases. Proteins, however, also carry unique identifying genetic markers able to distinguish individuals. In addition, proteins are more stable and more abundant than DNA. Consequently, skeletal remains that have been buried for extended periods or mixed with chemicals or burned still possess genetic markers that can tell us who a person was, bringing closure to families and

aiding the criminal justice system. NYC OCME is developing a fast, sensitive and inexpensive test capable of identifying individuals based on protein. Because differences in proteins can also distinguish species, this test is valuable for rapidly identifying fragmentary human remains following a mass disaster; it has also been used to distinguish human from non-human cremated remains. This research is funded by a competitive grant we received from the National Institute of Justice.

As I said at the start of my testimony OCME aspires to be as accurate as is humanly possible. The office I lead is committed to 100% accuracy 100% of the time. At my direction last May, OCME conducted an in depth analysis of the mortuary unit's operations that resulted in a number of recommended emergency corrective actions. In response I immediately directed my team to implement all measures necessary to gain control of operations and ensure rigorous quality control of OCME medicolegal and mortuary operations. I also made the difficult decision to assign the agency's highly trained doctors – the medical examiners – to a 'time-out' process that ensures quality control over the release of decedents.

These emergency measures strained my agency and its personnel and were simply not sustainable. With a new needs package I proposed what had to be done immediately to ensure that we sustain improvements, because even one inaccuracy has the potential to harm families and shake the faith and confidence of the entire community we serve.

As a result of my new needs request, the OCME was funded in November to hire a cadre of 9 Forensic Quality Specialists and one supervisor to lead them. By January 19, 2015 this cadre of specialists was hired, trained and successfully deployed throughout the agency's mortuary operations. Their primary role is quality control in the mortuary.

Additionally, to gain control of operations, I directed my team to establish an OCME Operations Center. Here, the agency tour commander, the Administrator on Duty (AOD), and the communication and transportation staff are collocated in the same work space under one organizational structure to respond to day to day forensic operations that manage information, manage resources and immediately respond and solve medicolegal and mortuary problems. We eliminated silos by implementing a Unity of Effort, Unity of Command to coordinate OCME Operations citywide, 24/7. To make this staffing model possible OCME received funding for 8 additional medicolegal investigators, 2 Administrators on Duty and 2 communications staff in the FY16 Preliminary Budget.

We also received funding to cover gaps in our Lab Information Management System and Security contracts, as well as baseline funding for a vehicle replacement schedule; additional T3 lines necessary for security cameras and data backup; heavy duty cleaning; and a replacement cycle for gurneys as they fall into a state of disrepair requiring disposal and replacement.

OCME's proposed Fiscal Year 2016 non-grant expense budget is projected at $48.6M for personnel and $ 15.5M for other-than-personnel services.

In summary OCME will use these expense funds to further improve the effectiveness of critical operations. We embrace excellence and promote a higher performing culture in all the OCME divisions to ultimately ensure 100% accuracy 100% of the time. In doing so, we will be working to implement our shared vision with the Administration for responsible fiscal management and the progressive values necessary to move NYC forward and to continue to make OCME Strong.

I am happy to answer your questions.

Testimony
NYC Council Health Committee
March 23, 2015
from AFSCME DC 37 Local 1549 Clerical-Administrative Employees
by
Oscar Alvarado, Special Assistant to Local President

Thank you for allowing me to testify and for all the past help you have given public health. Local 1549 represents over 4,000 clerical and administrative employees at the NYC Health and Hospitals Corporation (HHC) and its public HMO Metro Plus.

Privatization Kills Public Health

The cost of providing necessary quality services to the public continues to outpace this public system's cost of care and income. This is despite HHC's low administrative overhead. *HHC is the key to the making health care more accessible, especially in areas where the greatest disparities in health care exist.*

A New York Post article last year spoke about the excessive tax dollars received by large hospitals with high paid CEO's who do not service anywhere near the number of poor patients that HHC does. The article speaks to the need to support HHC and its mission to treat all those who come to its' doors.

Yet, the HHC continues on a mission to privatize. There are at least 500 private temps performing clerical duties in HHC. That represents 10% of the clerical work. We also see continued moves to privatize Dialysis and Appointment Call Center responsibilities. We believe that this compromises the quality of work performed and patient confidentiality.

Local 1549 2nd Vice President Ralph Palladino is a patient at Bellevue Hospital where private temps are working in the Appointment Call Center says, "*As an HHC patient, I am appalled and concerned that my Medical Records number will be known to private temp agency employees. I question the vetting and security issues concerning every HHC patient.*"

The city is proposing to spend more than $16 million on building Community Health Clinics in the next three years. This is wise. But the union believes, based on past history, that those clinics will be privately run, instead of being run by HHC, since the city council provided funding to expand these clinics a few years ago with public tax dollars and they are private clinics not staffed with public employees. We believe that public tax dollars should not be used to build private health care institutions while HHC continues to bleed. The City Council should inquire as to who will run these clinics.

In 1979, the city tax levy dollars provided 33% of HHC's funding. Now it is below 10%. This was curtailed courtesy of Mayor Giuliani who tried to privatize and destroy the public system.

Asking in Budget 2016

1. **Increased City Tax Levy funding for HHC, public health.**
2. **City and HHC cease privatizing HHC staffing and services and hire Civil Servants.**
3. **Funding for Community Health Clinics should be for PUBLIC facilities, not private gain.**

New York City Council – Health Committee Hearing

Monday, March 22, 2015, City Hall, Committee Room 10:00 am

Thank you Honorable Council Member Corey Johnson and Members of the City Council Committee on Health for convening this important preliminary budget hearing. My name is Carmen Charles, President of Local 420, DC37, AFSCME.

This afternoon I speak on behalf of my 10,000 members employed by the New York City Health and Hospitals Corporation (HHC). My members live and work in the communities where our City's public hospitals are located. They serve each patient who comes through the doors of HHC, regardless of ability to pay, with compassion, dedication and professionalism. They are the Nurses' Aides, Dietary and Housekeeping Aides, Patient Care Associates, Respiratory Therapists, Institutional Aides, Central Sterile Technologists and many others who are on the front line every day of the year. Whether it is a disaster, a snowstorm or a regular day, our members are working hard to care for all in need of health care. Our members serve over 1.3 million patients a year.

In the brief time that I have, I would like to stress that we are well aware of the financial challenges facing HHC due to reforms in healthcare, including Delivery System Reform Incentive Payment Program (DSRIP). We want HHC to continue to provide high quality service and we are committed to working together to find new revenues and achieve rational savings.

However, staff reductions, aggressive management, consolidation and elimination of critical services, and out-sourcing of vital direct and indirect patient care, have been a high price to pay for the patients, the underserved communities, and the dedicated civil servants who provide the care.

In May of 2010, HHC released its Four Year Cost Containment and Restructuring Plan to address a growing budget deficit, particularly in the area of Disproportionate Share Hospital funding that is vital to covering indigent care costs. HHC retained Deloitte Consulting (Deloitte) to develop a series of clinical and operational strategic

approaches that would meet the savings and revenue targets through cost-containment and revenue generating actions.

While HHC did not implement some of the more drastic recommendations issued by Deloitte, including, but not limited to, elimination of most of the outpatient specialty services and consolidation of these services into one acute care facility, and elimination of nearly all HHC long term beds, it is Local 420's contention that HHC's restructuring plan under the prior administration took a slash-and burn approach to choosing changes to guarantee the fiscal soundness of New York City's public health-care system.

Now HHC can become the model for public healthcare under the leadership of Dr. Ram Raju. In December 2014, Dr Raju attended the Local's General Membership Meeting. It was the first time in the history of HHC the President accepted our invitation to speak to my members about their. He emphasized the need to continue deficit reduction and the importance of working with us to keep hospitals open and fully operational. This commitment we take strongly. While there are instances where the President's word and the corporation's action do not align, I believe his intentions are honest and I will continue to give my members' support to his efforts . . . unless those efforts are detrimental to us.

There is still much work to do before all the issues from the Bloomberg era are resolved. At the February 26 meeting of the HHC Executive Board, I gave testimony expressing concerns about HHC's decision to renew the contract outsourcing its Dietary Services to Sodexo. My testimony urged HHC to explore and consider several service, quality, managerial, operational, and value-related issues identified in the expired contract. I reminded the Board that the savings Sodexo promised did not materialize; their menus were culturally insensitive; and managers created a hostile working environment.

The reduction in staff stemming from HHC's outsourcing resulted in the over use of agency workers. Hours of full-time employees are reduced or distributed erratically resulting in low worker.

Outsourcing of services is just a microcosm of similar managerial and operational issues that affect Local 420 workers. My members encounter the same problems in environmental and laundry services. Common issues that impact many of our facilities are:

- Over-zealous managers who are not well trained as supervisors, with poor communication skills, who rely heavily on harsh discipline rather than the progressive disciplinary practices of the corporation;
- Disregard for the union's CBA which creates a hostile work environment;
- Increased hiring of agency workers in place of full times employees as a means to cut costs by not offering benefits to these workers.

Extensive use of agency workers fuels a parallel workforce that needs to be reversed. Contractors are abusive and intimidating because these workers are not covered under our CBA. Not only are these agency workers ineligible for benefits, but are an added burden on the City's safety net. They also remain in these civil service jobs as "de facto" full time employees long after my members return to work; in some cases, for over 5yrs or more. The practice disrupts the career paths of HHC employees.

We urge HHC to not miss the current opportunity DSRIP presents, to target revenue-producing and cost-saving work for backfilling, training and upgrading my members who are already in these titles. We hope the HHC PPS will do so by establishing a program to encourage savings by reducing contracting out; including creation of a robust task force for training and workforce development.

There are solutions to what ails HHC. Local 420 would like to be a part of the process. We are committed to upholding the mission of HHC:

- To extend equally to all New Yorkers, regardless of their ability to pay, comprehensive health services of the highest quality in an atmosphere of humane care, dignity and respect.
- To promote and protect, as both innovator and advocate, the health, welfare and safety of the people of the City of New York.

- To join with other health workers and with communities in a partnership which will enable each of our institutions to promote and protect health in its fullest sense – the total physical, mental and social well-being of the people.

NEW YORK UNIVERSITY

TESTIMONY OF NEW YORK UNIVERSITY BEFORE THE NEW YORK CITY COUNCIL HEALTH COMMITTEE PRELIMINARY BUDGET AND AGENCY OVERSIGHT HEARING

March 23, 2015

TESTIMONY OF CONSTANCE ROBINSON-TURNER, PROGRAM MANAGER FOR THE NEW YORK UNIVERSITY COLLEGE OF DENTISTRY MOBILE DENTAL VAN

Chairperson Johnson, members of the Committee, thank you for the opportunity to speak today on the topic of crucial funding for the NYU College of Dentistry's Smiling Faces, Going Places Mobile Dental Van.

My name is Constance Robinson-Turner and I am the Program Manager for the NYU Mobile Dental Van. I am joined by Dr. Andrew Schenkel, Director of Community Dental Care Programs for NYU as well as Jennifer Cuervo, Guidance Counselor at New Heights Middle School to discuss NYU's request for discretionary funding of $300,000 for the dental van program.

For 15 years, the Dental Van has provided oral health care and dental education to over 2,000 children annually through visiting public schools, day cares and health fairs citywide. The City Council has provided annual discretionary funding to support the dental van for the past 10 years. However, in November 2013, the Bloomberg Administration funded certain City Council initiatives by "baselining" them in the Department of Health and Mental Hygiene's budget, including the dental van. We have learned that for FY16, DOHMH intends to use the dental van funds for other purposes within the agency, and not to provide dental services through a van program. In short, the funding that the City had provided in the past is no longer there, and the program stands at risk.

As many of you are aware, the mobile dental van program addresses the crisis many-low income children face in accessing quality dental care and, often times, is the first dentist a child experiences. The van provides oral health instruction in addition to direct care, such as fluoride treatments and restorations. We work with local elected officials and schools to identify high-needs areas throughout the five boroughs to schedule the van at those locations. Low-income children have 60 percent more untreated cavities than their peers at higher socioeconomic levels, making the need for bringing dental care into these communities through the van program especially vital.

In order to ensure the continued provision of crucial services for medically underserved children, NYUCD is requesting discretionary funding of $300,000 in new City Council funds in FY16. The Council has previously awarded annually $268,000 for the van, the increase of $32,000 in our request will result in 200 additional children being treated aboard the van in coming year; an increase the program is capable of meeting.

The dental van program has always enjoyed wide support among Council Members, and we now ask your support for our funding request which is critical to the program's survival. Teachers, principals, practitioners and parents can all attest to the tremendous impact this van has on the communities it visits. My colleagues will also discuss the importance of the program for schools and NYU dental students. Thank you.

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TESTIMONY OF JENNIFER CUERVO, GUIDANCE COUNSELOR AT NEW HEIGHTS MIDDLE SCHOOL

Good afternoon, my name is Jennifer Cuervo and I am a Guidance Counselor at New Heights Middle School in Brooklyn. I get to see first-hand the invaluable and irreplaceable work that the NYU Dental Van does in our community. The dental van has been visiting New Heights Middle School for the last two years, and each year, over 70 of our scholars received dental care aboard the van. Our scholars always return from the van with large smiles and only wonderful things to say about their experience, making a visit to the dentist something the children look forward to.

I speak for our counselors when I say that without this program, many children in our communities would not have access to quality dental care, as often times the mobile dental van is a students first trip to the dentist. On top of the excellent care they receive from the Dental School's skilled, friendly and enthusiastic practitioners, the children also receive essential oral health instruction that will serve to benefit them, and their entire family, for years to come.

This treatment and education would have been difficult to obtain for the medically underserved children in our school. Many teachers, parents and school administrators would certainly feel the dental van's absence if it were to cease its operations. I hope that the City Council will continue to fund this important program, and urge you to continue support of the program in the FY 16 budget.

Thank you again chance to talk about the community's positive experience with this incredible program.

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TESTIMONY OF ANDREW SCHENKEL, DIRECTOR OF COMMUNITY DENTAL CARE PROGRAMS AT NEW YORK UNIVERSITY COLLEGE OF DENTISTRY

Good afternoon, my name is Dr. Schenkel and I am the Director of Community Dental Care Programs at NYU College of Dentistry.

The Mobile Dental Van program is a focus of the school's education, service and patient care mission. The children we see on the van will not access care any other way if they lose the opportunity to access care through the van. Not because of lack of other opportunities (we are always available on First Avenue) but simply because Access to Care is a very complicated issue and for whatever reasons, these children access care through our van program. We know from our experience in the community that expecting them to access care some other way is unfortunately not realistic.

One final note about the van program is that the experience gives our students an opportunity to interact with the community, learn the needs of their local populations, and bring smiles to children who are in need of dental care. Such experience makes our students much more likely to continue this type of community service when they are in practice on their own either by working in a community clinic or volunteering their free time to help the underserved.

We hope that the City Council continues the crucial funding for this program in the FY16 budget. I thank you for your time and attention today.

Testimony of

Alana Leviton
Policy Associate for Health and Mental Health

Before the
New York City Council
Finance and Health Committees

Regarding the
New York City
Fiscal Year 2016 Preliminary Budget

March 23, 2015

Good morning. My name is Alana Leviton and I am the Policy Associate for Health and Mental Health at Citizens' Committee for Children of New York (CCC). CCC is a 71-year-old, privately supported, independent, multi-issue child advocacy organization dedicated to ensuring every New York child is healthy, housed, educated and safe. I would like to thank Chairs Ferreras and Johnson, as well as the members of the City Council Committees on Finance and Health for holding today's hearing regarding the City's Preliminary Budget for Fiscal Year 2016.

The Preliminary Budget takes important steps to address income inequality and improve child safety and well-being in New York City. Mayor de Blasio made clear at the budget briefing that the Preliminary Budget is just a first step towards developing the Fiscal Year 2016 budget and that there is a great deal more to look at and evaluate as we move towards the Executive Budget in April. This is good news because there are a number of areas that must be addressed in Fiscal Year 2016 in order to improve outcomes for New York's children and families.

Specifically, we look forward to an Executive Budget that makes the investments needed to: improve access to high quality early childhood education and after-school services; bring school breakfast to all classrooms and universal lunch programs to all schools; support primary preventive services that strengthen families and prevent abuse and neglect; and expand access to children's health and mental health services in schools and communities.

This testimony focuses on the new investments in the Preliminary Budget related to children's health, which we urge the City Council to support. In addition, the testimony highlights the City Council initiatives we hope to see restored and baselined, as well as the areas where we hope to see additional investments. We urge the City Council to focus on these areas as you develop your priorities and that you also urge the Administration to use the Fiscal Year 2016 Budget to make NYC a better place to be a child.

A) Preliminary Budget Proposals that Improve Outcomes for Children

CCC was pleased to see that the City Fiscal Year 2016 Preliminary Budget included several new investments that will strengthen children's access to high-quality health services in New York City.

1) Approve the Preliminary Budget to Create Neighborhood Health Hubs and Urge the Administration to Ensure these Hubs Provide Mental Health Services for Children and Families

CCC is grateful for the Administration's commitment to reduce health disparities through their plan to expand community health centers. CCC supports the Preliminary Budget proposal to add $8.2 million CTL to expand the availability of community-based health services in communities by co-locating community providers and other government agencies within Department of Health satellite offices.

Over the past decade, New York City has made significant progress in reducing poor health outcomes; however, disparities persist among racial and ethnic communities, as well as geographically. As an example, the citywide rate of infant mortality has declined by 27 percent; however, the infant mortality rate for non-Hispanic black mothers remains nearly double the

citywide average.[1] This is compounded by the fact that black women report late or no access to prenatal care significantly more often than white women (12.1% compared to 3.8%).[2] Similarly, since 2001, the citywide asthma-related hospitalization rate for children under 15 years has fallen from 6.5 visits per 1,000 youth to 5.1 visits per 1,000 youth; however, rates far exceeding this average are reported for every neighborhood in the Bronx, with some neighborhoods hovering over twice the citywide rate.[3]

While the specificity regarding which services will be available at the health hubs has to be determined, CCC appreciates the Department's recent revision to the Neighborhood Health Hub RFEI that expanded the list of targeted providers to include Article 31 outpatient clinics. Our research has shown that current capacity levels of children's mental health care in community-based settings fail to meet the existing level of need, especially for children under age five.[4] CCC will be following these developments closely to ensure the plans include critical health and behavioral health services for children and we urge the City Council to do so as well.

2) Support the Preliminary Budget Proposal to Invest $749,000 CTL in an Annual Child Health Survey

CCC supports the Preliminary Budget proposal to add $749,000 CTL to DOHMH's budget so they can implement an annual Child Health Survey and we urge the City Council to support this proposal as well.

The Child Health Survey is a critical tool for understanding the health and well-being of New York City's children. Annually collected estimates will help DOHMH to more regularly measure the City's progress on meeting key health and mental health goals for children and help direct public health funding to the most underserved and highest need communities.

The last and only DOHMH Child Health Survey was conducted in 2009. The inclusion of funding in the budget to annualize the survey is critical for informing and tailoring future interventions and determining where the City should focus more attention to improve health and mental health outcomes for children. We urge DOHMH to maintain the breadth of the 2009 survey by preserving previous measures[5] including but not limited to:

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[1] Summary of Vital Statistics: Infant Mortality. New York City Department of Health and Mental Hygiene Bureau of Vital Statistics. December 2012. Accessed on March 12, 2015 from: http://www.nyc.gov/html/doh/downloads/pdf/vs/vs-infant-mortality-report2011.pdf

[2] "Figure 4.02: Mothers Who Received Late or No Prenatal Care by Borough." Keeping Track of New York City's Children, Tenth Edition (2013).

[3] "Figure 4.14: Asthma Hospitalization Rates." Keeping Track of New York City's Children, Tenth Edition. Citizens' Committee for Children of New York, Inc. 2013.

[4] In 2012, on behalf of the New York City Citywide Children's Committee and NYC Early Childhood Strategic Mental Health Workgroup, CCC sought to estimate the gap between the need for mental health treatment slots and the number of treatment slots available for children throughout New York City. Through an analysis of prevalence data, we found that an estimated 47,407 children ages 0-4 in New York City have a behavioral problem and 268,743 children ages 5-17 in New York City are estimated to have a mental health disorder. While we were unable to identify the citywide unmet need, due to the lack of data for Queens and Manhattan, our analysis of slot capacity for Brooklyn, Bronx and Staten Island suggested that treatment slots exist for only *1 percent* of children ages 0-4 and *12 percent* of children ages 5-17 who have treatment needs.

[5] EpiQuery: Child Community Health Survey 2009. New York City Department of Health and Mental Hygiene Bureau of Vital Statistics. Accessed on March 19, 2015 from: https://a816-healthpsi.nyc.gov/SASStoredProcess/guest?_PROGRAM=%2FEpiQuery%2Fchild%2Fchildindex

- Current and past learning disabilities;
- Current and past developmental disabilities;
- Parent perception of child being difficult to care for;
- Parent concerns with child's emotional/behavioral development;
- Professional concerns with behavior, development or growth;
- Pediatric dental visits;
- Use of pediatric sealants; and,
- Family Access to Healthcare, including: health insurance coverage, ability to afford needed medical care, ability to afford timely filling of prescribed medication, and emergency room visits.

3) Support the Preliminary Budget Proposal to Improve the Well-being of Infants through the Child Reading Media Campaign

CCC supports the Administration's Preliminary Budget proposal to invest $1.06 million to enhance the development of our youngest New Yorkers through a media campaign that encourages parents to engage with their young children in play, reading, and singing to help stimulate brain development. One of the most important influences on a young child's growth and development is their relationship with their parents. A nurturing parent-child relationship ensures the emotional development of a child and sets the stage for lifelong cognitive, social, emotional and health outcomes. These positive relationships also serve a protective function, and can offset the effects of trauma and exposure to chronic stress. We urge the City Council to support this proposal.

4) Support the Mayor's Proposal to Develop 128 new Community Schools

CCC is grateful for the Administration's decision to expand the Community School model, which engages community resources and families into student success. The emphasis on creating linkages to community programs and bringing social services into schools will go a long way towards more holistically serving children and families, thereby improving both academic and developmental outcomes.

B) Restore and Baseline Council Initiatives to Maintain Children's Access to Health Services

CCC is grateful to the City Council for your ongoing commitment to advancing initiatives that better support the health needs of children and families. Unfortunately, the Preliminary Budget did not include funding for the City Council initiatives related to children's health. We will be urging the Administration to restore and baseline these items and we respectfully request that the Council make them a priority once again.

Specifically, we urge the City Council to work with the Administration to ensure the following initiatives are restored and baselined in the FY2016 Adopted Budget:

- $300,000 for the Infant Morality Reduction Initiative
- $150,000 to support the Callen Lorde Community Health Center

C) Strengthen Families' Access to Quality Health Services by Expanding Place-based Services

While the Preliminary Budget for Fiscal Year 2016 included critical new investments, we believe that the Executive Budget (and ultimately the Adopted Budget) must go further to improve the health care for New York City's children and families. We urge the City Council to support these new investments as you work to influence the Executive Budget.

1) Health Insurance Outreach and Assistance

CCC respectfully requests that the City Council create a new initiative, Access Health NYC, which would provide pre- and post-enrollment health insurance assistance to parents, children and individuals. We believe this would cost $5.5 million for citywide outreach and assistance.

Although New York City has one of the lowest rates of uninsured children of any large city in the country, approximately 70,000 children still do not have health insurance coverage.[6] The goal of this initiative is to link hard-to-reach and underserved New Yorkers, including uninsured children and families, individuals with disabilities, formerly incarcerated people, and families living in shelters, to healthcare coverage and existing free or low cost healthcare options. Furthermore, the success of the New York Health Exchange not only depends on new enrollments, but on the ability of new enrollees to use their health insurance. Many families have difficulty navigating the health insurance system, not to mention understanding basic terms associated with health insurance coverage such as premiums, networks, and co-pays. Access Health will help New Yorkers understand their rights as health care consumers and effectively use their new health insurance benefits to access timely, high quality care.

2) School-based Health Centers

School-based Health Centers play a vital role for children and youth needing primary health care by offering students on-site access to a range of primary, preventive and specialty care – including reproductive health services and behavioral health supports. By bringing health and mental health care to school grounds, student needs are far more likely to be evaluated and treated. The presence of school-based services is also markedly beneficial to children whose parents may not have the work schedule flexibility to access services in the community. The availability of health and mental health services in schools has been linked to higher test scores; fewer discipline referrals and fewer absences. Benefits extend beyond students who receive on site services and have been shown to improve the school environment and provide teachers, other school staff and parents with needed resources for children.

While the benefits of school-based clinics to students and their surrounding communities are numerous, unfortunately a fragile business model threatens their long-term sustainability. These satellite clinics operate under the auspices of licensed, not-for-profit health care institutions. They are required to serve all students seeking service irrespective of the student insurance coverage and are not allowed to receive a co-payment for services on school grounds. While school-based clinics claim payments from insurers (including Medicaid) for the delivery of care, they usually are only able to recoup a fraction of the total cost of care provided even after all efforts to maximize claims have been exhausted. These recurring insufficient payments inhibit their ability to be self-sustaining, and consequently jeopardize their long-term financial viability.

[6] Figure 4.4: Uninsured Children. *Keeping Track of New York City's Children, Tenth Edition (2013).*

As New York State's Medicaid program shifts to a managed care payment scheme, it is critical that the services rendered on school grounds be taken into consideration and that reimbursement methods ensure that payment is made for all services rendered – both to ensure students can access needed care, and to ensure that clinics are financially viable.

CCC is working with our colleagues at the state level to urge the State to create a special designation for these organizations within the managed care system that will simplify and streamline the billing system, and make certain that services rendered on school grounds are part of managed care benefit packages so that these school-based clinics can remain fiscally viable. We urge the City Council and the Administration to include this request in your state advocacy priorities. Moreover, we believe that in addition to ensuring the continuation of existing SBHCs clinics, we also must advocate to expand the number of schools with these services on-site. We hope that the City Council and the administration can work together to increase the City's investment in school-based health clinics.

3) Oral Health

Children's oral health is another health priority that requires immediate attention and action. Despite being largely preventable, tooth decay is the most common chronic childhood disease in America.[7] Children with poor dental health are three times more likely to miss school and more likely to have a lower grade-point average then their healthy peers.[8] Data from the 2012 New York Oral Health Surveillance Project shows that one in four 3rd graders suffers from untreated decay.[9] Consistent with many of the issues covered this morning, poor oral health disproportionally affects families from lower income communities, [10] as 32 percent of low income children have untreated decay compared to only 15 percent of children in higher income environments.[11] Despite having comprehensive dental coverage included in the Medicaid benefit, this coverage does not ensure care and in 2012, only 39 percent of eligible children received dental care.[12]

CCC is looking to the Administration to identify ways in which to increase the Medicaid take-up rate for children's oral health. We believe that there are a number of steps the City could take including: creating a public awareness campaign that highlights the long-term benefits of child dental care, assessing and ensuring there are enough pediatric dentists who accept Medicaid, expanding the pediatric mobile dental van program, and increasing the number of school-based or school-linked dental programs. In general, school-based services are a highly effective way of reaching disadvantaged communities that traditionally have limited local resources. Placing oral

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[7] "Hygiene Related Diseases," Centers for Disease Control and Prevention, http://www.cdc.gov/healthywater/hygiene/disease/dental_caries.html

[8] S.L. Jackson et al., "Impact of Poor Oral Health on Children's School Attendance and Performance," American Journal of Public Health. (October 2011) , Vol. 101, No. 10, 1900-1906

[9] 2012 NY Oral Health Surveillance Project, New York State Department of Health

[10] "Improving Access to Oral Health Care for Vulnerable and Underserved Populations." Institute of Medicine and the National Research Council, 2011.

[11] 2012 NY Oral Health surveillance Project, New York State Department of Health

[12] U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, *Annual EPSDT Participation Report, Form CMS-416 (State) Fiscal Year: 2012*

health preventive services directly into schools creates a point of entry into the dental care delivery system and access to preventive care that children might not otherwise have.

Conclusion

In closing, meeting child health needs is critical for the development of future productive New Yorkers. As you work to negotiate the Fiscal Year 2016 Budget, we hope that the administration and the City Council will work together to strengthen the health service delivery system for NYC's children and families.

Thank you for this opportunity to testify.

HealthPeople
Community Preventive Health Institute

552 Southern Boulevard ♥ Bronx, New York 10455 ♥ Phone: 718/585.8585 Fax: 718/585.5041 ♥ www.healthpeople.org

Chris Norwood, Executive Director

Testimony New York City Council health Committee March 23, 2015

Good Afternoon,

I am Chris Norwood, Executive Director Health People, Thank you for this opportunity. Health People is an unique organization, the city's largest entirely peer educator-based community organization with a 25 year record of effectively teaching prevention and self-care by having low-income people from high risk communities themselves become health educators. We have actually provided evidence-based health education to more than 10,000 South Bronx residents, all of it delivered by local residents who are themselves affected by chronic disease and AIDS.

From this very grass-roots perspective, we would like to make two important points today. The first is the great need for the ACCESS Health Initiative of CPHS. People not having insurance remains a terrible problem that doesn't just hurt the individual but interferes with the health of the community. For one example, we have surveyed our local re-entry population sent to the Bronx from state prisons and 59 % of them said they didn't have a Medicaid card on leaving prison. Unfortunately, these returning citizens have very high rates of mental health problems, substance abuse, hepatitis C and HIV/AIDS. Access NY will give us the ability to see they are enrolled in health insurance immediately, which is crucial not just to them, but to the health of the community and communities all over New York that face this same situation and need.

Another neglected need has been real diabetes prevention education---meaning the DPP—or National Diabetes prevention program a multi-session course that reduces the prospects that people who already have pre-diabetes will then develop diabetes by almost 60% twice as much as putting them on standard ~~education~~ medication. It was wonderful that the city is starting a DPP program with CDC funds. But we would like to focus on two ways to make this program more powerful. The first is that people in low-income communities where diabetes is now far and away the worst threat to health must be trained themselves to facilitate this extraordinary and life-saving course. That is the only way it will become a real part of these communities and achieve everything it can achieve.

As far as I know, at this time, Health People is the only group in the city which is training peers in that is community members who themselves have diabetes or pre-diabetes to deliver the

DPP. We have focused on training residents of public housing to teach other residents of public housing; in our most recent course at Betances Housing, I'm proud to say the residents on average lost 6.3% of their body weight. I am disturbed to say, however, that we did this by obtaining a small amount of private funding. No government at any level, despite the unprecedented rates of diabetes, is putting any money at all into training community members to take the lead and achieve these kinds of results that show community members bring a passion and commitment to helping their neighbors and neighborhood that makes all the difference in success. We hope New York City will be the place that makes that breakthrough and assures we have the DPP for all.

Thank you.

Gmail

Ireen Ninonuevo <ireenomri@gmail.com>

NYC COUNCIL TESTIMONY: COMMITTEE ON HEALTH
1 message

Ireen Ninonuevo <ireenomri@gmail.com>
To: Ireen Ninonuevo <ininonuevo@khcc-nyc.org>
Mon, Mar 23, 2015 at 1:34 PM

Good afternoon. My name is Ireen Ninonuevo from the Child Sexual Abuse Treatment and Prevention Program at Kingsbridge Heights Community Center. We are the only trauma specialized mental health program in New York City that is completely free to children ages 3-21 who have experienced sexual abuse. We don't require health insurance which allows us to customize treatment for each victim through play therapy, family therapy, and group treatment.

If you were in an auditorium full of 200 girls and 200 boys, at least 50 girls and 16 boys will be sexually abused by the age of 18. However, the numbers could be much higher because up to 60% of child sexual abuse incidents are not reported.

The trajectory for child sexual abuse survivors who do not receive treatment is negative. There is increased risk of major depressive disorder, suicidality and self harm, substance abuse, sexual trafficking, and post traumatic stress disorder. Survivors of sexual assault and child sexual abuse experience chronic medical conditions including back pain, hip pain, gastrointestinal issues, chronic fatigue, and spend 18% more on medical bills than those who were not victimized. In addition, approximately 48% of child sexual abuse victims engage in re-enactment of the trauma which in many cases mean that they have reactive sexualized behaviors toward other children. Research studies are indicating that trauma can be passed on from one generation to another. There is increasing evidence that it's not just about child rearing or family dynamics that affect a child's vulnerability to trauma, but that trauma changes the DNA's function. They've seen this in a landmark research in 1994 in which children and grandchildren of Holocaust survivors experience posttraumatic stress symptoms although they have not been through traumatic incidents.

The implications of untreated sexual assault is staggering. This means that if victims do not receive interventions, New York City families and communities generations from now will continue to struggle with the negative impact of trauma caused by sexual assault and child sexual abuse.

What if there's a virus that affects 25% of the population? What if that virus affects not just the patient's physical, mental health, academic and occupational functioning? What if that virus has a high percentage of being passed on to the next generations? We would call that an epidemic. Child sexual abuse and sexual assault are silent epidemics.

We are requesting the New York City Council to consider increasing the funding for Sexual Assault Initiative to $600,000. This will help us increase capacity and decrease the number of sexual assault victims in our waitlists. We want to be the generation that makes a significant contribution to stopping the intergenerational

cycle of child sexual abuse and sexual assault and we ask the Council to help us in pursuing this goal.

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Iraen Ninonuevo, LCSW
Child Sexual Abuse Treatment and Prevention Program
Kingsbridge Heights Community Center
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New York City Sexual Assault Initiative

Testimony

New York City Council
March 23, 2015

Tel (212) 523-4728 Fax (212) 523-4781 cvtcnyc.org

Good afternoon and a sincere thank you to Councilmember and Committee chair Corey Johnson, and other members of the Health Committee. I appreciate the opportunity to speak today on behalf of the increasingly important New York City Sexual Assault Initiative, which provides essential funding to 4 diverse sexual assault programs citywide, and allows us to continue increasing services to traditionally underserved populations of survivors.

My name is Christopher E. Bromson and I am the Assistant Director of the Crime Victims Treatment Center at Mount Sinai St. Luke's and Roosevelt Hospitals. CVTC has been helping survivors of interpersonal violence heal, completely free of charge, since 1977, and has been on the forefront of victims services since its inception.

The New York City Sexual Assault Initiative was first funded in 2005 by the speaker; $250,000 was distributed equally among 4 direct service programs in Manhattan, Brooklyn, Queens and the Bronx, plus the NYC Alliance Against SA. The monies were given specifically to increase services to underserved populations that we on the program level knew were experiencing immense barriers to service. **For Fiscal Year 2016, we are asking for a total of $600,000 to be distributed between four programs.** At CVTC, that 2005 funding meant the creation of NYC's first and still only program dedicated to serving male survivors of sexual assault, childhood sexual abuse and intimate partner violence. Before Council funding, CVTC treated about a dozen men per year. **Now, ten years later, men make up almost 20% of our overall client population.** Last year, **we treated 156 male survivors** both individually and in 4 different trauma-focused groups, specifically tailored to male survivors. Council funding allowed us to create outreach materials designed to normalize feelings and begin to lessen the intense shame that so often surrounds male survivors. Those materials and other outreach efforts have been so successful that we are now unable to meet the needs of all male survivors seeking services from us. Increased funding from the Council would allow us to hire an additional bi-lingual trauma-focused therapist to work with male survivors in both English and Spanish.

My colleague Ireen will talk more about the other components of the Initiative, but I would like to briefly call your attention to an issue that has really been bothering me lately. You've no doubt noticed the significant increase of sexual assault's presence in the media. Maybe it's just because I do this work every day, but it seems that we are now exposed more than ever to news stories about rape and sexual violence on campus and on the sports field, discussions about what consent is, these issues are getting a lot of attention. And overall, that's a good thing. Done in the right way, it helps people learn how to talk about these difficult topics. My struggle, though, is that despite all this discussion,

funding to help the people who have survived these crimes is being cut; significantly. In this current statewide budget, **funding to rape crisis programs is slated to be cut by 43%.** The Governor, DOH and OVS have all cut funding to rape crisis programs at a time when we're treating more survivors than ever. This means massive layoffs and program cuts, and ultimately thousands of survivors who won't receive the services they need to heal.

Over 2 and a half million NYC residents will experience some form of sexual violence over the course of their lifetimes, and I firmly believe that it is the City's responsibility to make sure the programs that sometimes help save their lives, have the funding necessary to do so.

THE NEW YORK CITY SEXUAL ASSAULT INITIATIVE
FISCAL YEAR 2016 FUNDING REQUEST

The New York City Sexual Assault Initiative is comprised of four of the city's leading sexual violence intervention programs. Combined the initiative annually serves an average over 2,000 victims of sexual assault including children, young women and men throughout five boroughs. In addition, the New York City Alliance Against Sexual Assault provides training to medical professionals to become New York State certified Sexual Forensic Examiners who are often times one of the first responders to sexual assault.

Sexual violence – including sexual assault, child sexual abuse, commercial sexual exploitation, trafficking and sexual harassment - cuts across boundaries of culture, class, education, income, ethnicity and age. Demand for services rises and shifts each year. It is vital to maintain high quality response to diverse populations across all New York City neighborhoods. These comprehensive services are critical resources to New York City and needs continued support from the NYC Council.

I. Programming/Service Areas

Child Sexual Assault	Sex Trafficking	Sexual Assault Forensic Examiner Training	Male Victim Services
BRONX	**QUEENS**	**CITY-WIDE**	**MANHATTAN**
Kingsbridge Heights Community Center	**Mount Sinai's Sexual Assault and Violence Intervention-SAVI**	**The New York City Alliance Against Sexual Assault**	**Mount Sinai St. Luke's- Roosevelt's Crime Victims Treatment Center-CVTC**
Only *free* and *long-term* treatment program for sexually abused children in the Bronx	Only *free* program to assist young victims of commercial *sexual exploitation*	*Largest* training institute for medical professionals to become NYS certified Sexual Assault Forensic Examiners	Only *free* and *long-term* program for male victims of sexual assault

II. FY2014 Service Impact

The Sexual Assault Initiative served over 2,200 victims and survivors of sexual assault and conducted over 10,000 counseling/training sessions in FY2014.

Kingsbridge Heights Community Center	Mount Sinai's Sexual Assault and Violence Intervention-SAVI	The New York City Alliance Against Sexual Assault	Mount Sinai St. Luke's-Roosevelt's Crime Victims Treatment Center-CVTC
Served **200 children** Conducted **1,538** counseling sessions	Served **859** clients Conducted **3,773** counseling sessions	Trained **158** medical professionals Conducted **400** training days	Served **992** clients Conducted **4,933** counseling sessions
36 children waitlisted	**10 people waitlisted**	**11 medical professionals waitlisted**	On an average, **2 clients/week** to be listed on waitlist

III. FY2016 Funding Request

The **New York City Sexual Assault Initiative** respectfully requests funding in a total of $600,000 - $150,000 for each group. The Sexual Assault Initiative assists victims of sexual assault in all five boroughs and prevents sexual violence city-wide. Last year, City Council generously granted a city-wide initiative of $300,000 shared evenly amongst the NYC Alliance Against Sexual Assault, Kingsbridge, SAVI and CVTC. Currently all four programs have waitlists with limited staff/resources unable to effectively respond to cases. No sexual assault victims should wait to receive services.

THE NEW YORK CITY SEXUAL ASSAULT INITIATIVE
FISCAL YEAR 2016 FUNDING REQUEST

IV. Proposed Program Activities

With $600,000 funding, the NYC Sexual Assault Initiative will:

SAVI	will hire a **Mandarin-speaking Master's level trauma therapist** to meet the needs of growing population of Mandarin-speaking trafficking survivors. This person will handle an average of 660 therapy sessions per year.
CVTC	will be able to hire a **Spanish Speaking trauma counselor** with experience working with male victims; eliminate waiting lists and provide a more timely and adequate response to Male survivors of sexual assault, childhood sexual abuse and intimate partner violence with individual counseling, complementary and holistic therapies and therapeutic support groups.
Kingsbridge Heights	will hire a Master's level bilingual Spanish trauma therapist to provide additional sessions. We will provide **3,000 individual therapy sessions** throughout the contract year (100% increase from 1,500). This will ensure at least 100 children and families will be provided service (an increase from 63). The additional funds will address the wait-list.
The Alliance	will hire **a full time training coordinator** to respond to increased need for training and certification of Emergency Room nurses, doctors and other professionals treating sexual assault victims in all five boroughs. The Alliance will continue to provide high quality care to the most vulnerable: child victims, LGBTQ, and people living with physical and developmental disabilities;
All Groups	will respond to an **increasing demand for training from colleges and universities** to help better deal with sexual assault cases

V. Prevalence of Sexual Assault In New York City

Sexual Assault is a serious public health, public safety and human rights issue of epidemic proportions:

- **1 in 5 women have been raped in their lifetime while 1 in 71 men have been raped in their lifetime.**[1]
- Children and adolescents are at particularly high risk. **Almost half of female** victims experienced **the first rape before age 18, and 28% of male victims** of rape were first raped when they were **10 years old or younger.**
- After homicide, sexual violence is the most costly violent crime in the U.S., **costing $151,423 per incident,** as measured in acute medical care, mental health services, lost productivity, and pain and suffering.
- **One of the most under reported crimes.** 2 out of 3 victimizations are not reported to police.

VI. Why Now?

In recent years, the rates of sexual assault in New York City have not decreased. While forcible rape has decreased by more than 10% in other counties in New York State, New York City has a **five-year upward trend**, with a total of 1,537 rapes reported to the New York Police Department (NYPD) in 2014.[2] The forcible rapes reported in 2013 represents **nearly 65% of the total number in New York State.**[3] To respond to growing needs in NYC's neighborhoods, the Sexual Assault Initiative's four programs are geared to address children, women, and men, community members living with physical and intellectual disabilities, LGBTQ communities, and people who are sexually exploited or trafficked.

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[1] The National Intimate Partner and Sexual Violence Survey (NISVS): 2010 Summary Report. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

[2] Mayor's Management Report. (2014). Retrieved from http://www.nyc.gov/html/ops/downloads/pdf/mmr2014/nypd.pdf This number includes forcible rape, intimate partner rape and rape reported in school

3. DCJS. (2014). Retrieved from http://www.criminaljustice.ny.gov/crimnet/ojsa/indexcrimes/Regions.pdf.

THE COALITION FOR ASIAN AMERICAN CHILDREN AND FAMILIES

New York City Council, Health Committee
March 23, 2015

Testimony of Noilyn Abesamis-Mendoza
Health Policy Director, Coalition for Asian American Children and Families

My name is **Noilyn Abesamis-Mendoza** and I am the **Health Policy Director of the Coalition for Asian American Children and Families (CACF).** CACF has a membership of almost 50 Asian-led and Asian-serving community and social service member organizations serving a multitude of different Asian ethnic communities. Established in 1986, CACF is the nation's only pan-Asian children's advocacy organization and works to improve the health and well-being of Asian American (AA) children and families in New York. CACF also coordinates Project CHARGE (Coalition for Health Access to Reach Greater Equity), a collaborative devoted to improving health care access for Asian American in New York City. In July 2013, CACF along with 16 of our Project CHARGE partners were awarded 5-year state contracts to serve as in-person assistors/navigators for the New York State of Health. Together, there are 46 navigators speaking 26 different languages among the Project CHARGE network. We are also a proud member of the People's Budget Coalition of Public Health.

We would like to thank the Health Committee and Chairperson Corey Johnson for holding this important hearing to discuss prevalent health issues impacting New Yorkers.

With the passage of the Affordable Care Act (ACA) in 2010, everyone has been asking, "What does this mean for me?" This question becomes even more pressing for the Asian American community, the State's fastest growing racial group where 1 out of 5 of the community is uninsured. CACF recognizes the tremendous gains that New York State has seen with the full implementation of the Affordable Care Act. Since 2013, over 2 million New Yorkers have enrolled in coverage through the New York State Health (NYSOH) marketplace with an estimated 15% or 300,000 being Asian Pacific American.

Through the ACA, New York has been given important opportunities to improve health access for uninsured and underinsured New Yorkers. During this time of creating a new health care system, now more than ever a thoughtful discussion of the resources necessary for individuals and families to access affordable, quality health care they need is critical.

We urge the City to ensure supports are developed and enhanced in order to adequately meet the needs of diverse communities, particularly those that are low-income, immigrants, communities of color, women and children, LGBT individuals, and people living with disabilities and chronic illness. For the well-being of all New Yorkers, **the City must prioritize the integration of best practices and culturally and linguistically appropriate strategies that support all communities - including Asian Americans.**

Today, I call on the City to:

1. **Fund the Access Health NYC initiative that will support community based organizations to link individuals to care.**

Background:

Currently, Asian Americans are by percentage the fastest growing community in New York. Of the **1.6 million Asian New Yorkers in New York State**, approximately 80% live in the New York City metropolitan area, nearly doubling every decade since 1970. They make up 14% of the City's and 8% of the State's population. In fact, New York City has the largest Asian American population of any U.S. city. Between 2012 and 2013, the proportion uninsured for Asian Americans increased from 19.6% to 21.4%. Compounding these issues are linguistic, cultural, financial, and immigration status barriers that prevent many in these populations from attaining quality health care. Consider these facts:

- Asian American trace their heritage to more than **40** different **countries** and speak more than **100** different **languages and dialects. 32%** of Asian Americans nationally are **limited English proficient,** meaning they do not speak English as their primary language and have a limited ability to read, write, or understand English.

- **29%** of Asian Americans live in **poverty**, the highest of all racial groups in New York City according to the Center for Economic Opportunity. 1 out of 2 Asian Pacific American children is born into poverty. Asian Pacific American poverty rates among seniors (26%) are higher than New York City seniors in general (19%).

- Prior to the implementation of the state marketplace, **1 out of 5** Asian American is **uninsured**, and the overwhelming majority of uninsured Asian American are **foreign born (71%)**. While the proportion of uninsured Asian American women decreased from 20.8% to 17.3%, the proportion if uninsured Asian American men increased from 18.1% to 25.4%. In addition, many Asian American are **self-employed, working in small businesses or in cash based industries** that are less likely to offer health benefits. Uninsured rates are further magnified in the Asian Pacific American community due to **immigration status, language barriers, and cultural stigmas** of accessing public benefits.

Challenges:

While many improvements and benefits have come from health care reform and the redesign of the state Medicaid program, there is still a long road ahead to ensure a truly inclusive and accessible health care system in which no one is left out. The federal law will impose an individual mandate for those individuals who are not insured and as such, the state has an obligation to ensure there is a seamless pathway to coverage for all residents.

While New York State is progressing in its implementation of the Affordable Care Act and Medicaid Redesign, it seeks broad level changes and often does not tailor its approaches to specific communities' challenges, leaving many behind without access to insurance and continued accessible care. Gaps still remain to instituting culturally competent and linguistically responsive policies that addresses the particular concerns and needs of the State's diverse communities. **While we recognize that the Asian American community greatly benefited from options on the Marketplace and the expansion of Medicaid – there still remains large segments of the population that do not have coverage.**

The New York State of Health has developed a number of strategies to address the needs of limited English proficient individuals such as the set up of a multi-language customer call center and outreach and education materials in the top 6 languages spoken in the state as required by the state E.O. 26. Additionally, the enrollment portal has translated into Spanish and plans for other languages are said to be rolled out in the coming months.

However, targeted culturally competent and language accessible outreach and education to the Asian American community fell short in many instances. The lack of adequate language assistance and targeted culturally competent marketing to the Asian American community lead to considerable misinformation and confusion and in some cases deterred them from enrolling in the marketplace, Medicaid, or CHIP even if they were eligible. It is especially confusing as information relayed on the both the

mainstream and ethnic news often focuses nationally with little differentiation to the specific state provisions that are often more expansive with regards to eligibility in insurance programs. This required many Asian-serving community based organizations to fill the gaps by translating and correcting existing marketplace materials and conducting outreach and education campaigns focused on Asian immigrants' eligibility for health programs in the City and State, often without financial support/funding.

Bi/multi-lingual navigators also spent additional time helping Asian LEP consumers because there were no translated applications, forms, notices, and other printed materials translated into their specific language. LEP consumers also required more assistance with using their insurance once they were enrolled as well. Thus, navigators were made to translate benefit packages, serve as the liaison between the client and insurance company, and provide one-on-one training on how to navigate the health system (choosing physicians, booking appointments, etc.). They also linked New Yorkers who are not eligible for marketplace health insurance because of their immigration status to affordable healthcare options like HHC Options, public hospitals, and community health centers and clinics. The duties of navigators often went above and beyond mere enrollment assistance.

New York is a model and leader for our health programs and initiatives. We have a tremendous opportunity to strengthen these coverage options for our residents and to ensure that uninsured individuals and families will still have access to the existing safety net. **We also have a chance to think differently and develop new strategies to provide health services and supports for those left behind by the ACA.** We strongly urge our elected officials to continue the commitment to guaranteeing health access to its residents and not to retrench from the promise of covering the uninsured.

Recommendations:

- **Fund $5.5 million for the Access Health NYC initiative that will support community based organizations to link individuals to care.** While the state invested considerably in supporting community based organizations to serve in various enrollment assistor roles, the state contracts restrict funding to enrollment activities only. In order to do outreach and education activities, community based organization either had to fundraise, divert other resources, or provide these activities pro bono. The burden fell on and continues to fall on community based organizations to spread the word about health coverage options because the state failed to adequately target many hard-to-reach communities such as Asian immigrants. Asian American CBOs provided tailored outreach and education through media, community workshops, and one-on-one assistance to individuals, families, and small businesses. In order to reach New Yorkers not yet connected to care, NYC needs to create a program that connects with underserved communities, including low-income people, immigrants, communities of color, women and children, LGBT individuals, and people living with disabilities and chronic illness. The key to a successful program to link underserved individuals to care is community-based organizations that speak to them in languages and manners in which they can understand. The City Council can unlock the potential of health care reform in New York City by putting $5.5 million for a new initiative, Access Health NYC, which would fund community-based organizations to link individuals to care. Access Health NYC is an urgently-needed initiative that recognizes that community is the key to ensuring that all New Yorkers have access to health care.

Conclusion:

Thank you for this opportunity to provide testimony. The changes that are forthcoming as a result of the ACA should not come at the expense of already underserved and vulnerable communities. Efforts should ensure that health disparities are not further perpetuated and strides should be made towards health equity for all residents in New York State. We hope the New York City Council Health Committee will take our recommendation into account when determining how best to ensure all New Yorkers have access to the quality, affordable health care. We look forward to working closely with all of you in the coming months.

DEDICATED EXPERIENCED SUPPORT

SHARE

for women facing breast and ovarian cancers

New York City Council Health Committee
SHARE: Self-Help for Women with Breast or Ovarian Cancer
Testimony delivered by Jacqueline Reinhard, Executive Director and
Ivis Sampayo, Senior Director of Programs
March 23, 2015

On behalf of SHARE and the more than 32,000 women we serve each year, thank you for the Council's outstanding, ongoing support of SHARE and the Ambassador initiative, most recently with an FY15 grant of $135,938. The bi-lingual Ambassador initiative directly serves 6,000 medically underserved African-American, Latina and immigrant women each year, ensuring that they have the information and support they need to protect their health.

The Ambassador Program was started by SHARE to address the health-care disparities among women in low-income communities of color that have been well-documented in numerous studies over the past decade. According to the Centers for Disease Control and Prevention, "Black women have the highest death rates of all racial and ethnic groups and are 40% more likely to die of breast cancer than white women. The reasons for this difference result from many factors including having … fewer social and economic resources. To improve this disparity, black women need more timely follow-up and improved access to high-quality treatment."

Latina women are about 20 percent more likely to die of breast cancer than non-Latina white women diagnosed at a similar age and stage, according to the American Cancer Society. Latinas are significantly more likely to present at a later stage with larger tumors that are more difficult to treat. It is believed that these disparities exist because of different access to treatment and lower rates of mammograms in the Latina community.

SHARE's Ambassador Program is a grassroots effort intended to reach and empower medically underserved general populations in the African-American and Latino communities in New York City. This program educates and trains African-American and Latina women who are survivors of breast or ovarian cancers and their family members to serve as advocates in their own communities.

The Ambassadors work in communities throughout the Bronx, Brooklyn, Manhattan and Queens. In 2014, 10 African-American and 12 Latina women served as SHARE Ambassadors. Through their collective efforts, they made a total of 90 presentations at health fairs, community, medical, and senior centers in their respective neighborhoods. In total, their efforts reached 5,975 individuals in their communities in 2014 – a record number for this initiative. SHARE maintains a database to track all aspects of the program.

In addition, we offer bilingual printed materials (more than 11,000 distributed in 2014), helplines, support groups (10 Latina and 2 African American, 1,268 attendance), and Survivor Patient Navigation at Bellevue and Mt. Sinai St. Luke's Roosevelt hospitals (approximately 500 served).

Numbers don't put a human face on our work. One recent story stands out – Lisa Franklin, an ovarian cancer survivor and dedicated Ambassador who so moved WNBC anchor Pat Battle that she devoted a segment to her personal story and outreach work. Although Lisa's own prognosis has deteriorated in the last month, she continues to devote herself to educating and empowering other women.

The Ambassador initiative has made a critical difference in the health of African-American and Latina New Yorkers – from the breast cancer survivor who had her daughter undergo genetic testing after attending a presentation at a library in Queens, to the young Latina who was ready to stop her breast cancer treatment without the support of SHARE.

As you know, the City Council's Cancer Initiative funding has ended. Without it, SHARE may have to drastically cut the education and support services it offers to these women. Although an RFP has been issued for cancer screening and navigation services, it is limited to colon cancer-related services. Although this is a worthy cause, it neglects some of the greatest risks to women's health, particularly in the African-American and Latina communities – breast and ovarian cancers.

Funding from the Cancer Initiative enabled SHARE to address these vital aspects of women's health through a comprehensive, grassroots program that reached a full spectrum of New York City women from the general public, through diagnosis and post-treatment. SHARE has managed to offer these services in a cost-effective manner through the dedication of a community of survivors whose diversity reflects the communities in which they work.

In 2015, SHARE is piloting a new initiative under the auspices of the Ambassador Program to reach medically underserved women at the point of diagnosis – the "On-Site Help Desk." Trained volunteer community members will be placed at Lincoln Medical and Mental Health Center in the Bronx, and New York Hospital Queens to answer questions, provide information, emotional support, and practical help to underserved women. The volunteers will also work to increase healthcare providers' awareness and understanding of the needs of medically underserved and immigrant patients. After the pilot program has been evaluated, we hope to replicate this program at other NYC hospitals in subsequent years.

Another new initiative in 2015 will increase focus on immigrant communities through outreach at consulates. Currently, SHARE offers services at the Mexican, Ecuadorean and Peruvian consulates, and we plan to expand to additional consulates in the months ahead.

All of this vital work will be jeopardized if our funding is cut in 2015. We hope you will support SHARE and the thousands of medically underserved African-American and Latina residents of the Bronx, Brooklyn, Manhattan and Queens we serve by helping us secure a new source of funding for the critical work we do in promoting and protecting women's health.

DEDICATED EXPERIENCED SUPPORT

SHARE

for women facing breast and ovarian cancers

ABOUT SHARE

SHARE provides dedicated, experienced support for women facing breast and ovarian cancers, all from survivors who've been there. Founded in 1976, SHARE reaches tens of thousands of people annually through our free services and our online and print materials.

Support Groups
People affected by breast or ovarian cancer share experiences and are led by a trained facilitator.

Helplines
Callers talk to survivors and caregivers and get a viewpoint that can only come from someone who's been there.

Educational Programs
The public learns what's happening in breast and ovarian cancer from the experts.

LatinaSHARE
Spanish-speakers have access to support groups, educational programs, and helplines in Spanish.

SHARE Ambassadors
Latinas and African-Americans in underserved NYC communities learn what to do if they encounter symptoms.

Pink & Teal Seminar Programs in the Corporate Workplace
Employees learn about breast and ovarian cancer in the workplace from people who've had personal experience with these diseases.

Caregiver Circle for Family & Friends
People caring for others facing these diseases get the support they need to help their loved ones and themselves.

Survivor Patient Navigator
Women in breast clinics at St. Luke's-Roosevelt and Bellevue Hospitals get information and support from survivors in their native language as they cope with their breast cancer diagnosis.

Advocacy Initiatives
Women with cancer use their own experiences to help improve others' lives.

SHARE
1501 Broadway, Suite 704A • New York, NY 10036 • 866-891-2392
Contact: Beth Kling, Communications Director, 212-937-5573

Testimony presented to the
NYC Council Health Committee Budget Hearing
March 23, 2015

Dear Members of NYC Council Health Committee:

I thank the NY City Council Health Committee and Chair Corey Johnson for your support of our Public Health System and for hearing our comments today.

I am Anne Bove, President of HHC and Mayoral Executive Council for the New York State Nurses Association. I represent 8,000 nurses who work for HHC.

As many of you know, I am a Nurse at Bellevue hospital and have worked in the public health system in NYC for more than 37 years. The New York State Nurses Association is a member of the People's Budget Coalition.

NYSNA fully supports Access Health NYC because it has the potential to provide healthcare access information to underserved communities in a culturally and linguistically competent way. It is an appropriate responds to city's increasingly diverse populations, as it would reduce disparities in health services and address inequities in accessing primary care.

I would be remiss, in the context of the issue of health disparities, if I did not bring to your attention again the issue of the transfer of HHC's Chronic Dialysis Services to Big Apple LLC/Atlantic Dialysis at four HHC hospitals (Harlem, Lincoln, Metropolitan, and Kings County). There are three points I want to make:

First, on average, dialysis patients die sooner in the Big Apple system. Why would we allow the transfer of patients to a company with higher death rates?

The State Department of Health has failed – THREE TIMES – to approve the Big Apple application. At issue are these differences in death rates. Patients have protested, and public health experts and doctors have joined that protest. It is outrageous that such a transfer is still under consideration.

Second, the nephrologists who work at HHC say: DO NOT SELL TO BIG APPLE!!
For over a year you have been told that the Big Apple deal was a good one because the

HHC doctors supported it. However, TWENTY Nephrologists- some of whom work for Big Apple/Atlantic- opposed the sale!!

In a letter to DOH committee, they wrote: "We urge you to vote against Big Apple Dialysis running the dialysis centers at Harlem, Kings County, Lincoln and Metropolitan Hospitals… We believe that any change of this magnitude should include the front line nephrologists, and unfortunately we have not had a meaningful role in this process."

They go on to say that HHC's high standard of patient care and its mission are put at risk in this sale.

Three, HHC will be exchanging high quality care for meager – if any - savings: We believe the financial savings claimed by HHC in this matter are grossly exaggerated in company submissions.

HHC listed its estimated net annual savings at $15.2 million. However their report does **not** include income from Acute (inpatient) Care Dialysis.

There are other factors:

HHC by its own admission fails to receive full reimbursement for its chronic outpatient treatment. That should be addressed.

There is additional acute care treatment revenue to be made, as well as capturing full reimbursement for chronic dialysis treatments. HHC should be increasing existing capacity by adding a third shift --- all of these factors would serve to add revenue and, we believe, bring any annual deficit for chronic dialysis care down to within a million dollars, including fees paid to Big Apple under the proposed deal.

In a $7 billion annual budget, this amount is negligible.

The health issues, on the hand, are **enormous**.

That's why we are asking this committee to hold a hearing as soon as possible so that patients, their families and community members can have a real forum on this life and death issue.

Thank you for your time and consideration of this matter.

Anne Bove,

President HHC and Mayor Executive Council
New York State Nurses Association

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

nyc.gov/hhc

NEW YORK CITY COUNCIL

FISCAL YEAR 2016

PRELIMINARY BUDGET HEARING

COMMITTEE ON HEALTH

RAMANATHAN RAJU, M.D., PRESIDENT

NEW YORK CITY

HEALTH AND HOSPITALS CORPORATION

MARCH 23rd, 2015

Good afternoon Chairman Johnson and members of the Health Committee. I am Dr. Ram Raju, President and CEO of the New York City Health and Hospitals Corporation (HHC)....your public hospital system. I am joined by Ms. Marlene Zurack, our Senior Vice President and Chief Financial Officer and Ms. LaRay Brown, Senior Vice President for Strategic Planning, Community Health and Intergovernmental Relations. Thank you for the opportunity to discuss our Financial Year 2016 Preliminary Budget and Financial Plan and programmatic initiatives. In my testimony, I will outline the strategic priorities that I have established for our corporation, review our financial plan and provide an update on recent key initiatives.

At the beginning of this year, I put forth four strategic priorities to preserve HHC's mission. These priorities will benefit our patients, our staff and our bottom line. They are:

- **Expand Access to Care**
- **Increase our Market Share**
- **Stabilize our Financial Health and**
- **Focus on Workforce Development**

Expand Access to Care: When I first came before the Council last year, I said that we could not rest on our laurels for what we have achieved. While

we have made significant progress on many fronts, including the strengthening of preventive and primary care services we provide, there is more that needs to be done. We will work to expand access to care so that our patients can more readily receive the care they need - when they need it. We have already expanded hours on nights and weekends in every borough so that our patients have a wider range of appointment times. We will continue to adjust schedules based on demand and feedback from our patients.

Another way to expand access is to reduce wait time. We are working to reduce the time it takes for patients to see their doctors and finish their appointments. By becoming more efficient, we can create additional capacity and save our patients time.

Next, we are working on a system to allow patients to log in to a secure site where they can review their medical information such as care plans, lab results, diagnoses, discharge information and more. Patients will also be able to send messages to their providers. By providing patients with tools that help them to play an active role in their own care, we expect they will become more engaged with their healthcare and remain healthier as a result.

Next initiative is to increase our Market Share: Right now, we serve roughly one out of every six New Yorkers. I want this number to grow over the next five years. If we can continue to improve the patient experience and increase customer satisfaction rates, we will see the proverbial needle move in the right direction. Our patients can be our best advocates, but only if they are satisfied with their experience.

As patients spread the word about the great care they receive at HHC, we expect our new partners will do the same. HHC will be working with many community organizations and other healthcare organizations as part of New York State's Delivery System Reform Incentive Payment Program (DSRIP). I will discuss DSRIP later in my testimony but I'll briefly mention how this relates to increasing market share.

Under DSRIP, the State's goals are to, "promote community-level collaborations and focus on system reform, in order to achieve the state and federal governments' goal of a 25 percent reduction in avoidable hospital use over five years. The Performing Provider Systems (PPSs) are required to collaborate with one another to implement innovative projects focusing on system transformation, clinical improvement and population

health improvement." Given this mandate, HHC will be working with more than 200 partners on numerous DSRIP projects over the next five years. If we are successful, these partnerships will prove effective in attracting and retaining new patients.

However, our best partner in attracting and retaining new patients is MetroPlus. MetroPlus is HHC's award winning health plan. It is perennially ranked as the best or among New York State's highest performing Medicaid managed care plans in terms of customer satisfaction and quality. They now have more than 469,000 members. My goal is for this number to grow to 600,000 by the end of Financial Year 2016. We have already formed alliances with HRA and DOHMH as well as Community Based Organizations that provide navigator services about how to work together more closely. We are hoping through these partnerships to leverage the next two cycles of open enrollment and capture new members into MetroPlus and assist the uninsured to obtain Medicaid, join a qualified health plan, or ultimately sign up for the State's Basic Health Plan as it rolls out.

Recently, enrollment has increased with the coverage expansions resulting from implementation of the Affordable Care Act. Medicaid membership crossed the 400,000 barrier for the first time in

December of last year and now stands at 411,000. Additionally, MetroPlus' Qualified Health Plan enrollment has more than 27,000 members now after the most recent open enrollment period. This number will likely increase through April, as individuals discover during the tax filing process that they will face penalties and choose to sign up for coverage instead.

Next priority is to stabilize our Financial Health: The members of this Committee know all too well about our budget gaps and all too well that to accomplish our essential mission we need financial security. Each year we need to find new ways to close the gaps that result from our structural budget deficit. If we achieve the goals I just outlined, we will be in a better position to fulfill the goal to stabilize our finances and protect our unwavering mission to turn no one away.

While increased revenues from new patients is an important part of our strategy it is not enough. We need to obtain the fairest prices possible from our vendors and we must manage our supply chain. Also, we need to consistently raise critical reimbursement issues with all of our payers. Currently, we are in the early stages of implementing managed care for our behavioral health services. We have uncovered and begun discussions with the

State about an important Medicaid behavioral health under-funding issue. This issue is one of many about which we are in negotiations.

Our final strategic priority is to focus on workforce development. A diverse, well-trained, mission-driven culturally competent staff is one of our greatest assets. As we work to increase the tools available to improve the patient experience, we also need to invest in both new and ongoing programs that benefit our 36,804 employees. We are expanding e-learning opportunities for staff so that they have opportunities outside of the traditional training rooms to learn new skills. We are investing in programs to train our managers to design systematic improvements and make strategic decisions. We are also identifying the next generation of leaders within HHC. In order for the next generation of leaders to be ready to meet future challenges, we must work now to develop the skills they will need.

As part of this effort, we are working with our labor partners in an innovative and collaborative way. For example, in our recently signed agreement with the New York State Nurses Association (NYSNA), we have committed to establish facility-based Nursing Practice Councils that will work with a corporate-wide Nursing Practice Council to

improve, among other things, patient satisfaction, patient outcomes, and employee satisfaction. These councils will be comprised of an equal number of members of NYSNA and nursing management. The councils will employ innovative, collaborative and evidence-based techniques to achieve its goals.

Financial Plan

As I mentioned, we work constantly to identify methods to reduce and eliminate our budget gaps. Through restructuring, cost-containment, revenue optimization and the ongoing support from the City, we have been successful in balancing our budget. Last year at this time, we were projecting a $430 million gap for Fiscal Year (FY) 2015. This deficit was projected to grow to nearly $1.4 billion in FY2018.

Currently, we are projecting a FY 2015 closing balance of $1 billion. Before you ask if that number is a typo, let me caution that this positive balance is solely attributable to the anticipated receipt of several years of outstanding Upper Payment Limit (UPL) funds totaling $1.2 billion before the close of this financial year. I want to stress that these funds do not recur. These are one-time funds that were due to us for services rendered between years 2012 and 2014. If we didn't have these UPL funds, our

deficit would have been negative $920 million, or negative $227 million on a cash basis.

After this year, our gaps revert back to the pattern of deficits growing each year. Before corrective actions, we project a $753 million gap in FY 2016. These gaps grow to slightly more than $1 billion in FY17 and further balloons to $1.5 billion in FY19. As with any financial plan, we are developing corrective actions to address these gaps. I can more fully discuss these at our next budget hearing.

One step we are taking now is through a productivity based benchmarking initiative to right size staffing levels across the Corporation. This measure will monitor full time equivalent positions globally, including our affiliate staff, temporary staff and use of overtime. This will allow the hospitals more discretion to fill positions with full time and part-time staff while reducing their reliance on temporary staff and remain within their productivity based target.

There are risks and opportunities that could alter our forecast. Our plan does not include current budget proposals on the table in Albany or in Washington. The 2015-2016 State Budget that should be passed in the next week may include a modest amount of new funding for a quality

improvement program. There is also a proposal to eliminate a readmissions penalty that would save us $4 million. The positive benefit of these items will likely be lost though if a reduction in Medicaid reimbursement for certain low-income Medicare Beneficiaries, or dual eligible, is approved.

One of the most important items for us in this year's Executive Budget was the proposed extension of the State's charity care laws for three years and granting of new authority to the State Health Department (SDOH) to revise Disproportionate Share Hospital (DSH) funding formulas without having to seek further legislative approval when Federal DSH cuts begin in Federal Fiscal Year (FFY) 2017, which begins October 1st, 2016. To remind the Committee, the DSH program provides federal Medicaid matching dollars to states to make payments to hospitals that treat a disproportionate share of uninsured and Medicaid patients. The DSH funding that we receive is critical to supporting our mission and allowing us to serve low-income and uninsured patients.

We believe that the State's policy should be changed so that DSH funds follow the patients and is directly targeted to hospitals that serve disproportionately high numbers of uninsured patients and Medicaid members. We advocated for a mechanism to revise the distribution to allow input

on changes and requirements that the funds are targeted. We are concerned that without changes to the present methodology of distribution of DSH funds we will absorb all of the initial federal DSH cuts. We are optimistic that the State Budget will include a financing workgroup with our participation to come up with recommendations to the Legislature and Governor on how DSH funds should be disbursed in the event of Federal cuts. We appreciate your help and support with your colleagues in Albany.

As it stands now, we estimate a potential loss of $180 million in total DSH dollars during FFY 17, which spans our Fiscal Year 17-18. This grows to $508 million in total dollars in FFY18 and more than $3 billion over the period from FFY17 to FFY24. DSH cuts are slated to expire in FFY 24 but may be extended further to pay for other initiatives. For example, the President's budget proposes to add another year of DSH cuts in FFY25.

The preliminary budget also reflects our latest projections for the impact of the Accountable Care Act. Our Financial Plan assumes a 12.5% reduction in uninsured patients by FY 19 translating into $50 million in additional revenue that year. The plan also recognizes significant increases in Medicare DSH payments. However the Medicare DSH payments will decline over the life of the plan as more people

gain insurance. These increases in Medicare DSH funds are not to be confused with cuts we will see in Medicaid DSH funds that I just mentioned. While we will see gains in Medicare DSH funds, we will lose Medicare funds due to payment reforms that are projected to cost us up to $35 million annually.

In FY 16, the ACA is expected to provide a net $206 million dollar benefit to our corporation. However, this benefit is short-lived. When you calculate the loss of Medicaid DSH funding, this translates to overall ACA reductions of $130 million by FY 18 and $138 million in FY 19.

On a bright note though, our application for federally qualified health center look-alike designation of Gotham Health was approved last month by the Health Resources & Services Administration (HRSA). We estimate that we will eventually receive an additional $30 million per year in federal funding to support our strategic goals to expand access to geographically convenient and culturally-sensitive healthcare services for all New Yorkers and strengthen our ability to keep New Yorkers healthy. I want to thank Council Member Johnson for writing a letter to HRSA on our behalf.

We were pleased that as part of the Preliminary Budget, we received funding for the collective

bargaining agreements reached with our union partners, as well as funding for Ebola preparedness and the Cure Violence program.

We have budgeted increased revenue in two key areas. The first is through increased MetroPlus enrollment that I mentioned. We are anticipating $15 million this year as a result. The other source is the DSRIP funding that was part of the Federal Medicaid waiver that New York State received approval for last year. These dollars are to be used to support delivery system reforms throughout New York State. Over the next five years, investments will be made to improve access, care management and care coordination consistent with transformation goals set forth in the waiver.

<u>DSRIP – OneCity Health</u>

As part of DSRIP, entities were required to form and be approved as Performing Provider Systems (PPS). Our PPS, OneCity Health, submitted its application with the State in December. We were required to perform Community Needs Assessments to analyze the needs of different neighborhoods. Then we were required to choose projects from a list created by the State to address these needs. There were three main categories: System Transformation, Clinical Improvements projects and Population-wide

projects. Our application details our approach to meet community needs through eleven projects. These include initiatives to further increase access to care, develop care coordination programs, develop primary care and behavioral health integration initiatives and develop IT initiatives to link these programs on a population-health improvement based platform.

We expect to hear soon what our performance awards will be. Unless there are delays, funds are expected to begin to flow in mid-April. Initially these will be mainly for process requirements but will transition to performance based payments over the course of the Waiver. In our Financial Plan, we currently project $60 million in DSRIP funds in FY15 - these are now below the line. Once the awards are announced, we will bring this amount above the line in the next plan. It is important to emphasize that these funds are not grant funds and should not be considered as a solution to our budget deficits.

There is a second component to DSRIP funding which is for capital projects. These funds are intended to support sustainability of DSRIP transformation efforts. We submitted an application for HHC specific projects totaling $435 million last month. These projects are critical to achieving the important goals of improving access, care

coordination and sharing information with our partners which include many community based organizations.

Capital

Turning now to our own Capital Program, work has been completed or is near completion on several major projects. Gouverneur Healthcare Services in lower Manhattan is preparing for a Grand Reopening ceremony next month to mark the completion of its major modernization which includes a renovated, state-of-the-art skilled nursing facility with an additional 80 beds.

At North Central Bronx Hospital (NCB) we completed renovations to the Labor and Delivery Suite and reopened this vital service last fall. We are very grateful to Council Member Ritchie Torres, Council member Andrew Cohen and members of the Bronx delegation who provided capital funding in last year's budget to make this possible.

At Elmhurst Hospital in Queens, we will open a new Women's Health Pavilion in the coming months which will expand access to prenatal care and comprehensive OB services.

As a follow up to a hearing the Council held in 2013 on access to healthcare services for women

with disabilities, the Council appropriated $2.5 million in Capital funding in FY 2014 to make improvements at our facilities. These funds will be used to make renovations and purchase equipment to make exam rooms and bathrooms optimally accessible for persons with disabilities. The first phase of our preliminary design work including cost estimates is complete and construction will begin later this year at four of our sites. We are very appreciative of the Council for this investment and ask that you consider restoring the additional $2.5 million that was previously allocated but eliminated from the FY15 capital budget.

FEMA Award

Before I conclude, I will share with you the details of our recently announced FEMA award to rectify the damage caused by Hurricane Sandy. As you know, our corporation suffered serious losses as a result of Hurricane Sandy. We experienced physical damage to four of our facilities and nearly $250 million in losses due to the closures of Bellevue and Coney Island hospitals. I was extremely pleased to stand with Mayor de Blasio and Senator Schumer last fall when they announced an award of 1.723 billion dollars to complete repair and protect our hospitals that were damaged. We are working

closely with the Mayor's Office of Recovery and Resiliency on these projects. I am very thankful for all the support and advocacy we received from the Council which helped us immensely with this award.

The award includes:

- **$923 million for Coney Island Hospital to build a free-standing building on the hospital's campus that will be raised above the 500 year flood level to house critical infrastructure, including the Emergency Department, imaging services and surgical suites. This project would also include funding for the hospital's power plant. This amount includes funds previously awarded to make repairs to the hospital's basement, first floor and electrical systems;**
- **$499 million for Bellevue Hospital to pay for restoration work on electrical systems and equipment already completed. This will also pay for the installation of flood walls and gates to protect the hospital to the 500 year flood level, new flood proof elevators and to raise vital infrastructure out of the basement;**

- **$181 million for Coler to build a flood wall, pay to replace the generator that was destroyed**

and create additional protection to this critical facility's electrical systems; and

- **$120 million for Metropolitan Hospital to build a flood wall around the facility and pay for electrical repairs.**

In summary, by achieving the strategic goals I have outlined, we will succeed in this dynamic and challenging health care environment with our mission intact.

We will continue to find ways to mitigate losses in revenues from traditional sources.

We will continue our pioneering work to align how we deliver care with a transformed delivery model that emphasizes population health.

And, we will continue to collaborate with our labor partners to develop ways to engage our workforce in meaningful ways.

We appreciate the Council's support and believe that with your support, we will continue leading the way, both here in New York City and nationally, away from "sick care" and towards a new era of true health and wellness care, aimed at empowering New Yorkers, without exception, to live the healthiest life possible. This concludes my testimony. I now look

forward to listening to your comments and answering your questions.

Testimony For New York City Council Health Committee Preliminary Budget Hearing on Monday, March 23, 2014, City Hall, Committee Room 1:00 pm

Thank you Honorable Council Member Corey Johnson and Members of the City Council Committee on Health.

My name is Moira Dolan and I am the Senior Assistant Director, Research and Negotiations. I am representing Henry Garrido, our newly appointed Executive Director of District Council 37, AFSCME. District Council 37 represents 120,000 municipal employees and 50,000 retirees

This afternoon I speak on behalf of the 17,000 members of District Council 37 (DC 37) employed by the New York City Health and Hospitals Corporation (HHC). Our members are the Nurses Aides, Dietary and Housekeeping Aides, Clerical Associates, Respiratory Therapists, Social Workers, Computer Aides and Laborers on the front line every day of the year. Whether it is a disaster, a snowstorm or a regular day, our members are working hard to care for all in need of health care. Our members also use the quality centers of excellence at HHC's nationally recognized eleven (11) acute care hospitals, four (4) skilled nursing facilities, six (6) federally qualified health centers, 32 primary care clinics in the community, Health Home Care division and the MetroPlus Health Plan, Inc.. We serve over 1.3 million patients a year.

NO Privatization of Dialysis

We continue to oppose the privatization of chronic dialysis services at the four major hospital facilities serving patients at Kings County, Harlem Hospital, Metropolitan Hospital and Lincoln Hospital. We have already experienced the privatization of other services including laundry, dietary, and management of environmental services with very mixed results. The line must be drawn when it comes to core patient services. The selected vendor, Big Apple, has a poor record with patient outcomes according to data from the Center for Medicaid Services. Our patients are not units for profit maximization. The approval process is currently in the hands of the NY State Public Health and Health Planning Council. The next meeting of the full PHHPC is May 11th in NYC and we urge you to join us to protest any decisions to turn over this service to a private vendor.

Problems with other privatization efforts have shown it doesn't work for the best interests of the patients or the staff. Last month HHC approved a ten year extension of a contract with Sodexho despite our feedback regarding numerous issues with the abusive treatment of staff, irregular schedules, and insufficient staffing to meet the workload of preparing and delivering patient food that will lead to higher satisfaction scores.

Headcount Reductions Must Come from the Temporary Workforce

Over the last several years facility managers relied on filling positions with temporary agency staff rather than full time per annum staff. These temps have no rights, no benefits and no job security. They have no reason to be committed to HHC's mission and cause morale problems for the full time staff. HHC recognizes that relying on this itinerant workforce is no longer a reliable strategy going forward. As a result of projected revenue loss going forward, planned actions by June of 2016 include a reduction of 1,000 "global FTES", which includes agency, hourly, affiliation as well as full time regular staff.

Dr. Raju has indicated that these reductions will include the temporary workforce, that they cannot keep cutting the full time workforce. We hope and pray that they are serious about cutting temps first. You may recall that last year we testified that HHC had cut 3,737 heads as a result of the five year plan. Clearly we have been cut enough already. Benchmarks will be developed for standardized work across the corporation. The benchmark should NOT be the minimum possible staffing levels and should recognize the varied conditions that exist in each community.

DSRIP and Workforce Development

Despite all this bad news, there is some possibility for good news as well. HHC is awaiting final determination of the funding that will flow through from the Medicaid waiver program called Delivery System Reform Incentive Payment. The intention of this program, as Dr. Raju has testified, will transform the way health care is delivered throughout HHC over the next five years to provide more primary and preventative care to patients, prevent avoidable hospital admissions and improve health care outcomes all while reducing costs overall.

Our 17,000 members are part of the vital support network of providing care by doing everything from making those primary care appointments, to taking blood pressure, to providing social work services to insure that the patient has the appropriate supports at home to care for themselves.

Within the DSRIP program it is anticipated that there will be further redeployments and retraining of staff. The application includes significant funds for workforce development and training. There will be areas where the work will change somewhat due to fewer inpatient admissions overall and greater outpatient primary and preventative care. Skills upgrading, technical training on electronic medical records and health prevention efforts will all be part of Workforce Development. We are evaluating the number of members in titles that are likely to decline, as well as the areas where there will be growth in order to work collaboratively with HHC on the appropriate training.

Payroll problems-

We are willing to work with HHC on improving patient outcomes and workforce development but we also need them to deal with our concerns. Our members continue to be frustrated by payroll problems that get fixed in one location and recur in another facility. These issues have been raised at the highest levels as well as directly at the facility and yet they persist. The only reason we raise it here at the City Council is to indicate that while we want to work with them, our members need to be respected if HHC expects them to work harder in a challenging environment. At the very least workers deserve to be paid what they are entitled to.

ACCESS HEALTH NYC –

Finally, we support CPHS agenda items including Access Health NYC. New Yorkers need a number of ways to find and manage their health care options that recognize their language, culture and health status. Access Health NYC will be a valuable resource in connecting underserved communities to health care.

Michelle Villagomez
NYC Legislative Director
AMERICAN SOCIETY FOR THE PREVENTION OF CRUELTY TO ANIMALS

Hearing before the New York City Council's Committee on Health, Fiscal Year 2016 Preliminary Budget

March 23, 2015

Good afternoon. I am Michelle Villagomez, New York City Legislative Director for the American Society for the Prevention of Cruelty to Animals (ASPCA). On behalf of the ASPCA and its nearly 70,000 New York City supporters I would like to thank Chairman Johnson, Councilmember Vallone, and the Health Committee for the opportunity to testify today in support of establishing and maintaining full-service animal shelters in every borough.

A lack of funding has been a major obstacle to our joint efforts to save the city's homeless animals, and with the passage of Local Law 59 in 2012 and much-needed funding increases to Animal Care and Control we were able to mitigate many of the problems AC&C was experiencing. The restoration and expansion of animal care and control services was a critical first step in the long-term rebuilding of the New York City shelter system. Now, under the careful guidance and strong leadership of Executive Director Risa Weinstock, AC&C has consistently made improvements that continue to drive a higher live release rate, and we're confident that if the city properly invests in a quality animal care and control program throughout the five boroughs, we will see unprecedented progress for our most vulnerable residents.

However, the need for full-service animal shelters in the Bronx and Queens remains dire. Presently, these boroughs only have animal receiving centers, which do not provide permanent shelter, medical, or adoption services for homeless animals. Instead, animals brought to these centers must be transported to already taxed shelters in Brooklyn and Manhattan, which creates the unnecessary problem of moving lost animals far from the neighborhoods where they are found. This in turn makes it harder for owners to find their beloved pets. For decades this situation has shortchanged taxpayers, depriving them of a basic municipal service in their own communities. Putting the problem in perspective, if the Bronx and Queens were a single city, their combined population of nearly 3.6 million people would make them the third largest city in the country. Given the size and population of these boroughs, it is inconceivable that in 2015 they still do not have a shelter. Nearly all the members of the Bronx and Queens delegations agree with this point and support dedicating funds to build and operate shelters in their boroughs.

The ASPCA recommends allocating between $40- $50 million to build full-service shelters in the Bronx and Queens and an additional $7.5 million for each shelter's recurring

annual operating costs. These are estimates, and shelter costs vary based on many things like the cost of site acquisition. We are excited to work with AC&C to provide best in class services to New York City's pets.

We urge the City Council to pass and appropriately fund Intro. 485. We need to ensure that New Yorkers, no matter where they reside, can access these very important community services.

Thank you.

PRIMARY CARE DEVELOPMENT CORPORATION

www.pcdc.org

Testimony from the Primary Care Development Corporation
to the New York City Council Health Committee on the 2015-16 Preliminary Budget

March 23, 2015

Chairman Johnson and members of the New York City Council Health Committee - thank you for the opportunity to submit this testimony. My name is Dan Lowenstein, and I am Senior Director of Public Affairs for the Primary Care Development Corporation (PCDC) – a nonprofit dedicated to expanding access to high quality primary care in underserved communities throughout New York. Over the last 22 years, PCDC has assisted over 200 healthcare provider organizations in 41 Council Districts (see attached).

Since its founding in 1993, PCDC has been **a key source of capital** for the primary care sector in New York City. As a AAA+2 federally designated Community Development Financial Institution, PCDC has financed more than 80 primary care projects across the five boroughs, valued at more than $400 million. This investment has created capacity to provide over 1.75 million medical visits annually to meet the primary care needs of roughly than 600,000 underserved residents of New York City. PCDC has also transformed 630,000 square feet of frequently dilapidated space into economically vibrant primary care practices and has created or preserved over 1,600 construction jobs and over 2,100 quality permanent jobs in low-income communities. PCDC also provided **training and technical expertise** to more than 100 New York City hospitals, community health centers, special needs providers and private practices, helping providers redesign operations, train staff, and become "Patient-Centered Medical Homes." Finally, PCDC advocates for **policies and public funding** that strengthen and sustain the primary care sector, including successful advocacy for medical home Medicaid incentive payments and capital funding to expand capacity.

Who is Keeping the Primary Care Promise to New Yorkers?

Primary care has time and again demonstrated the ability to improve health outcomes, lower healthcare costs, and reduce disparities. Yet today, 2.3 million New York State residents lack access to primary care. It will take more than 1,100 primary care providers and more than $1 billion in capital to build the primary care capacity to meet this need. This situation should come as no surprise, as only about 5% of our health care dollar goes to primary care. We have underinvested in primary care for too long. The Delivery System Reform Incentive Program (DSRIP) – a $6.4 billion New York State initiative to reduce avoidable hospitalization by making health care more effective and less costly – is our best opportunity to strengthen and expand primary care. Our expectation is that at the conclusion of DSRIP:

- The vast majority of New Yorkers will have regular and unfettered access to primary care;

- The vast majority of primary care providers will be practicing in true patient centered medical homes/advanced primary care models;
- Primary care spending as a proportion of total health spending will at least double from current.

We believe there are ***Five Principles for Primary Care Success*** that should be followed to ensure DSRIP delivers on this Primary Care Promise (see full principles attached). We hope these principles will inform the City Council's policies related to ensuring our neighborhoods have access to effective primary care:

1. Every Performing Provider System (PPS) should have a Primary Care Plan that should specify how the PPS will ensure access to quality primary care for their population.
2. True primary care access and quality must be measured throughout DSRIP Implementation.
3. Meaningfully represent primary care in PPS Governance.
4. Prepare the workforce to support new primary-care-centered care models.
5. Ensure availability of sufficient financial resources for primary care impact.

We have been encouraged that DSRIP could truly deliver on this promise. New York State and all 25 DSRIP Performing Provider Systems (PPSs) - including all of those in New York City – have committed to ensuring every primary care provider in their network is a high-performing Patient Centered Medical Home (PCMH)/Advanced Primary Care (APC) practice – a model of primary care that emphasizes access, coordination, full integration with other healthcare services (including behavioral health), and population health management to ensure that patients are getting the right care, at the right time, in the right setting. New York State officials will also be requiring that each of the PPSs submit a primary care plan that we hope tracks their progress toward goals primary care capacity, access, quality and sustainability goals. Finally, community health centers and other safety net community providers are, by and large, participating in PPSs and are part of the PPS governance structure, though whether they have a seat at the table for critical decisions that impact primary care remains to be seen.

Meeting these primary care goals requires strong commitments and sufficient and sustained resources, so we were very concerned when the Governor's Executive Budget contained cuts and omissions that threaten to undermine the critical role primary care plays keeping low income families and communities healthy – through DSRIP and otherwise. The Executive Budget:

Cuts $30 Million in Medical Home Funding for 6,000 Primary Care Providers Serving 2 Million Low-Income Patients: Cuts announced March 4 to take place April 1 will reduce by up to 50% or completely eliminate incentive payments for roughly 6,000 NCQA-recognized PCMH primary care providers serving roughly 2 million Medicaid enrollees. A practice with 2,500 Medicaid enrollees will

see a $60,000 cut. Although NYS will increase Medicaid incentives payments for providers who reach new and more demanding standards, virtually no providers to date have pursued or achieved these tougher standards.

Ignores the Capital Needs of Community-Based Healthcare Providers while Providing $1.4 Billion for Hospitals: PCDC estimates that the community-based healthcare sector needs more than $1 billion in capital to meet the needs of underserved communities. While the Executive Budget includes $1.4 billion in capital for hospitals ($700 million for Brooklyn and the rest upstate), community-based providers – the critical front end of the healthcare system – will receive nothing.

Allows Adequate Medicaid Rates for Primary Care Doctors to Expire: New York State Medicaid pays only 42% of Medicare rates for primary care providers – one of the lowest rates in the nation. (Medicaid Managed Care pays about 75% of Medicare). The Affordable Care Act provided a 2-year "bump-up" that increased rates to Medicare levels, but this provision expired in January, 2015. The higher rates promote greater access – more doctors treating Medicaid enrollees, and more of them. Letting the rates expire reverses this progress. Some states are covering the Medicaid/Medicare gap – but New York State is not.

Budget Recommendations

We are hopeful that the Legislature will correct these issues. Whether or not they do, the New York City Council has a crucial role to play in expanding access to primary care.

Support Mayor de Blasio's initiative to expand community-based primary care. There is an urgent need for health center capacity in New York City. Fully 26 neighborhoods in all five boroughs have been identified as in need of greater access to primary, according to a 2013 study by the Community Health Care Association of New York State (CHCANYS) and federal data on primary care shortage areas.

We support the initiative in the Mayor's 2015-16 budget would provide $16.5 million to develop 16 community health center sites in underserved neighborhoods throughout New York City. Fulfilling a pledge made during the campaign, the Mayor's initiative would make city-owned or controlled spaces available for new clinics and provide direct financial support for the creation and expansion of new clinics through technical support and short-term infusions of working capital to help ramp-up operations.

This funding is important, but it won't be sufficient. Our calculations show the cost of fully developing a health center averages about $7.5 million for each 10,000 patients served, including site acquisition, preconstruction, construction, and startup costs. These costs can vary considerably, though, particularly due to site acquisition. Health centers will need to leverage other sources of funds,

including affordable private sector financing. That's why it is essential that a New York City develop a loan guarantee program to encourage more responsible lenders to provide affordable loans to health centers.

Support PCDC's New York City Primary Care Safety Net Access Project. Despite busy waiting rooms and harried providers, many primary care practices are not operating at optimal capacity. Effective strategies for scheduling appointments, deploying care teams and making effective use of the time patients spend in a facility can make a major difference in patient access to care. It is estimated that with effective strategies, providers could increase patient access by 30% or more without sacrificing care.

PCDC requests $500,000 from the New York City Council in FY '16 to help safety net primary care providers increase access to healthcare in low-income communities. With this funding, PCDC will assist 10 safety net primary care locations in primary care shortage areas maximize patient access with their existing resources. Benefits to patients will include: greater access to primary care, same-day and walk-in appointments, reduced wait times, and more coordinated care.

Support the NYC Department of Health and Mental Hygiene Division of Prevention and Primary Care. New York City can and should be playing a central role in all healthcare transformation efforts. Thankfully, we have important assets in the Department of Health and Mental Hygiene that can partner effectively with New York State in the area of health planning and primary care expansion. The Division of Prevention and Primary Care is the natural linkage to State-based transformation efforts. That Division works to reduce barriers to primary care in underserved communities by tracking indicators of primary care access including coverage and provider workforce supply, preventive medical and dental services, and primary care screenings. It also includes the Primary Care Information Project (PCIP), which works to improve the quality of care in medically underserved areas through health information technology, promoting new models of care focusing on prevention and public health priorities, and population health management.

Support and expand the Primary Care Emergency Preparedness Network: While most of the emergency preparedness focus tends to be on hospitals and nursing homes, a resilient health system must include community-based care needs commensurate emergency preparedness resources at the community level. Patients with flulike symptoms from Ebola, for instance would more likely show up at a primary care provider's office than a hospital.

PCDC and CHCANYS have partnered to manage the Primary Care Emergency Preparedness Network (PCEPN), with support and oversight from the NYC Department of Health and Mental Hygiene Office of Emergency Preparedness and Response. PCEPN's goal is to support primary care providers in New York City to be optimally prepared for, and respond to community and citywide health needs during

the response and recovery in the event of a disaster or emergency. PCEPN played an important role in preparing primary care during the Ebloa emergency, Superstorm Sandy and the 2009 H1N1 flu emergency.

With PCEPN, for the first time, primary care sector secured itself as planning partners of NYC Emergency Operations Center within the Health & Medical Unit. Today, there are 31 PCEPN "members," representing over 120 primary care delivery sites in underserved communities throughout New York City. We recommend that the focus on primary care emergency preparedness be augmented, and additional resources be deployed to expand and strengthen PCEPN.

Ensure Health Plans Covering City Workers Invest in Primary Care. As a major purchaser of healthcare for its workers, New York City has significant ability to direct the health plan covering its workers to invest more in primary care. We are not privy to what New York City's health plan spends on primary care, but primary care is roughly 5% of total healthcare spending statewide. We will never have true cost savings if insurers don't increase their spending on primary care. We are advocating for state changes to ensure that all health plans double their investment in primary care. New York City could set the example by making this a requirement for any health plan covering city workers.

Conclusion

Just as we need to invest in maintenance of water mains and gas lines, roads and bridges to protect health and safety and prevent more expensive repairs down the line, we have to invest substantially in a primary care system that will prevent illness and save money from more expensive health care interventions down the line. Rapid changes in healthcare, combined with major state-driven transformation initiatives, provide the opportunity for New York City to develop a dramatically more efficient and cost-effective healthcare system that will improve the health of New Yorkers while reducing how much we spend on health care. Primary care is at the heart of this new model. We hope the City Council will make investment in primary care a priority for New York City's neighborhoods, and we look forward to working with the Mayor, City Council, and all elected representative to ensure that all New York City residents have the healthcare the deserve.

Contact: Dan Lowenstein, Senior Director of Public Affairs, 212-437-3942, dlowenstein@pcdc.org

PRIMARY CARE DEVELOPMENT CORPORATION

www.pcdc.org

DSRIP MUST DELIVER ON THE PRIMARY CARE PROMISE:
FIVE PRINCIPLES FOR PRIMARY CARE SUCCESS

More than two million New York State residents lack sufficient access to primary care. The Delivery System Reform Incentive Program (DSRIP) is our best opportunity to strengthen and expand primary care, which is central to achieving better health for patients and communities, and lower costs for everyone. New York State and all 25 DSRIP Performing Provider Systems (PPSs) have committed to this vision, including ensuring every primary care provider in their network is a high-performing Patient Centered Medical Home (PCMH)/Advanced Primary Care (APC) practice. Our expectation is that at the conclusion of DSRIP:

- The vast majority of New York State residents currently without primary care will have regular and unfettered access;
- The vast majority of primary care providers will be practicing as true PCMHs/APCs;
- Primary care spending as a proportion of total health spending will at least double from current levels;
- Evidence of primary care value to health care quality, outcomes and costs will be clearly demonstrated and reflected in value-based payment models.

Five Principles for Primary Care Success should be followed to ensure DSRIP delivers on this Primary Care Promise:

1. **Every PPS should have a Primary Care Plan.** Primary care plans should specify how the PPS will ensure access to quality primary care for their population. All plans should include:
   a. An assessment of current primary care capacity, performance and needs, and a year-by-year plan for addressing those needs;
   b. How primary care expansion and practice and workforce transformation will be supported with training and technical assistance;
   c. How primary care will play a central role in an integrated delivery system;
   d. How value-based payments will enable primary care to achieve quality outcomes and cost savings;
   e. How these efforts will be supported financially throughout and beyond DSRIP.
2. **Measure true primary care access and quality throughout DSRIP Implementation.** Access metrics should include: ratio of patients to providers and exam rooms, panel size and payor mix, physicians accepting new Medicaid/uninsured patients, timeliness and availability of appointments (including same-day), hours of operation, use of telemedicine and other non-facility based engagement and cultural competencies that reflect the needs of their communities.

Quality metrics should determine: impact of primary care, care coordination and care management on health care quality, outcomes, utilization and cost.

3. **Meaningfully represent primary care in PPS Governance.** Given the central role of primary care in a transformed healthcare system, those with clear experience in and commitment to advanced primary care models must have tangible influence at all levels of the PPS, including its Steering Committees, Clinical Governance Committees, Project, Finance and Budget Committees.

4. **Prepare the workforce to support new care models.** True PCMH or APC require fundamental change in the skills, competencies and deployment of the healthcare workforce. Workforce development plans should demonstrate how the PPS will ensure the healthcare workforce can fill new job categories, work in multidisciplinary teams and participate meaningfully in the management of patient and population health.

5. **Ensure sufficient resources for primary care impact.** Less than 6% of the health care dollar is now spent on primary care. PPS budgets should clearly identify up-front and ongoing resources dedicated to expanding and transforming primary care. This includes practice transformation and workforce support, DSRIP incentive payments, value-based reimbursement and capital funding for expansion and modernization.

What You Can Do to Ensure DSRIP Delivers on the Primary Care Promise

The ability of DSRIP to deliver on the Primary Care Promise impacts all of us. If you want to DSRIP to work for primary care and transform healthcare for the benefit of all families and communities, take action now:

- Adopt these principles into your advocacy message.
- Read the PPS DSRIP applications and their scoring, which are now online.
- Follow the DSRIP Project Approval and Oversight Panel, which will be holding public meetings February 17-20. (Public comments on Feb 17th. All meetings webcasted.)
- Read and comment on the DSRIP PPS Implementation Plans, due on March 1.
- Meet with PPS leads in your community and attend open sessions of their governance bodies.
- Discuss your concerns with New York State DSRIP officials and your elected representatives.

For more information: Dan Lowenstein, PCDC Senior Director of Public Affairs: dlowenstein@pcdc.org

About the Primary Care Development Corporation (PCDC)

Founded in 1993, PCDC is a nationally recognized nonprofit organization dedicated to expanding and transforming primary care in underserved communities to improve health outcomes, lower health costs and reduce disparities through three key program areas: Capital Investment, Performance Improvement, and Policy and Advocacy. PCDC's impact includes more than $515 million invested in low-income communities, 1 million square feet of primary care capacity developed, 900 healthcare organizations strengthened to deliver patient-centered primary care, 7,000 healthcare workers trained and 765,000 patients with improved access to primary care.

PRIMARY CARE DEVELOPMENT CORPORATION

OVER 200

PCDC has helped expand primary care access in over 200 care organizations in 44 NYC Council Districts

Councilmember Inez Barron
- Brookdale Family Care Center at Linden Blvd. & New Lots
- Brooklyn Adult Care Center
- Brooklyn Boulevard ALP
- Dr. Betty Shabazz Health Center
- Sr. Thea Bowman Medical Health Center
- East New York Diagnostic & Treatment Center
- Housing Works, East NY Primary Care

Councilmember Fernando Cabrera
- Adult OutPatient Clinic
- Burnside Family Care Center
- Fordham Tremont Community Mental Health Center Division
- Fordham Termont-Grand Concourse
- Latin American Immigrant Services
- Morris Heights Health Center at Burnside & Walton
- Walton Family Health Center
- Jewish Home & Hospital-Bronx Division
- HELP/PSI-CitiWide Harm Reduction & Wellness
- Mount Hope Family Practice
- Women & Family Clinic

Councilmember Margaret Chin
- APICHA Primary Care Clinic
- Asian & Pacific Islander Coalition on HIV/AIDS
- CHCANYS
- Margaret Sanger Center- Planned Parenthood
- SEIU Local 32BJ
- Access Community Health Center
- Betances Health Center
- Charles B. Wang Community Health Center, Inc.
- Chinatown Health Services
- Comprehensive Care Management Corporation at Grand St.
- Downtown Health Center
- Gouverneur Healthcare Services
- HealthCare Choices, Inc.
- Judson Health Center
- Smith Communicare Health Center

Councilmember Andrew Cohen
- Mercy Community Care
- Montefiore Family Health Center
- Riverdale Manor

Councilmember Robert Cornegy
- Bedford Stuyvesant Family Health Center
- Woodhull Hospital & Medical Center

Councilmember Laurie Cumbo
- Brooklyn Plaza, Inc.
- Pierre Toussaint Family Health Care Center

Councilmember Laurie Cumbo (cont.)
- Brooklyn Plaza Medical Center
- Center for Nursing & Rehabilitation
- Cumberland Diagnostic & Treatment Center
- Fort Greene Health Center

Councilmember Maria del Carmen Arroyo
- Fordham Tremont South (Southern Medical Group)
- Lincoln Medical & Mental Health Center
- Neighborhood Family Health Center-Narco Freedom
- Bronx Health Center
- El Nuevo San Juan Health Center
- Bronx Family Center
- Dr. Martin Luther King, Jr. Health Center
- Health Center at Tremont
- Melrose Houses Child Health Clinic
- Montefiore Community Pediatric Programs
- South Bronx Children Health Center for Children & Families

Councilmember Chaim M. Deutsch
- Coney Island Hospital
- Sheepshead Bay Primary Care Center
- Shore View Nursing Home
- Harbor View Home

Councilmember Inez E. Dickens
- Harlem United
- Renaissance DTC
- Thelma Adair Davidson Medical & Dental Center
- Family Health Center of Harlem Lott Assisted Living
- ArchCare Senior Life
- Drew Hamilton Houses Health Center
- Harlem United- 124th St. & Lenox Ave.
- Helen B. Atkinson Health Center
- Saint Nicholas Child Health Center
- Sydenham Health Center
- Center for Comprehensive Care-Morningside Clinic

Councilmember Rafael Espinal
- Lamarca Family Health Center
- MediSys Health Network
- Wyckoff Heights Medical Center Ambulatory Care

Councilmember Mathieu Eugene
- Premium Health Services
- Scharome Manor
- Caribbean House Health Center
- Kings County Hospital Center
- Newkirk Family Health Center
- SUNY Downstate Medical Center

Councilmember Julissa Ferreras
- Castle Senior Assisted Living
- Elm-York Assisted Living
- Madison-York Assisted Living, Corona

Councilmember Daniel Garodnick
- Bellevue Hospital Center
- Children's Aid Society
- Help PSI
- The Altman Foundation

Councilmember Vincent Gentile
- Bensonhurst Center for Rehab & Healthcare
- Lutheran Family Health Center, Shore Road

Councilmember Vanessa Gibson
- Morrisania Diagnostic & Treatment Center
- Bronx-Lebanon Hospital
- Dr. Martin Luther King, Jr. Health Center

Councilmember David G. Greenfield
- Maimonides Adult Primary Care Center
- Stepping Stone Pediatrics

Councilmember Corey Johnson
- Housing Works- Chelsea
- Housing Works
- VillageCare Rehabilitation & Nursing Center
- Care for the Homeless
- Covenant House
- UNITE HERE Health Center
- West Midtown Medical Group
- YAI/Premier Healthcare
- Callen-Lorde Community Health Center
- Ryan Chelsea Clinton Community Health Center
- St. Luke-Roosevelt Hospital Center
- The Hearst Foundations OB/GYN Associates
- The Village at 46th & Ten
- University Medical Center Associates
- Covenant House New York

Councilmember Ben Kallos
- Mary Manning Walsh Nursing Center
- NY Children's Health Project
- Phyllis & David Komansky Center for Children's Health
- The 80th St. Residence
- Mt. Sinai Adolescent Health Center

Councilmember Andy King
- Gunhill Health Center
- Laconia Nursing Home
- Workman's Circle Multicare

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PRIMARY CARE DEVELOPMENT CORPORATION

Councilmember Peter Koo
- Flushing Manor Care Center
- Flushing Manor Nursing & Rehabilitation
- New York Hospital Medical Center of Queens

Councilmember Karen Koslowitz
- St. John's Queens Family Health Center

Councilmember Brad Lander
- Ezra Medical Center
- KCH Fifth Avenue Women's & Children's Health Center
- Lutheran Family Health Center, Park Slope
- SUNY Downstate Medical Center- Long Island College Hospital
- Brooklyn Health Information Exchange

Councilmember Rory Lancman
- Damian Family Care Centers
- Margaret Tietz Center

Councilmember Stephen Levin
- Greenpoint Community Health Center
- ODA Primary Health Care Center
- Premier Healthcare- Brooklyn Heights
- Howard Rosman, MD

Councilmember Mark Levine
- Community League Health Center
- Family Medicine at the Herman Denny Farrell, Jr.
- Heritage Healthcare Center
- Phase Piggy Back
- Grant Houses Clinic
- Riverside Health Center
- Saint Luke's Roosevelt Hospital Center
- William F. Ryan Community Health Center
- Charles B. Rangel Community Health Center
- St. Mary's Center

Councilmember Alan Maisel
- VersaCare of Foster Avenue
- Crown Nursing Home & Rehabilitation

Councilmember Melissa Mark-Viverito
- All Med & Rehabilitation of New York
- Ogden Family Medicine & Dental Center
- Segundo Ruiz Belvis Diagnostic & Treatment Center
- Boriken Neighborhood Health Center
- Harlem United
- La Clinica Del Barrio
- Metropolitan Hospital Center
- Settlement Health & Medical Services Inc.

Councilmember Steven Matteo
- Eger Health Care & Rehabilitation Center
- New Broadview Manor

Councilmember Darlene Mealy
- Brownsville Multi-Service Family Health Center-Genesis
- Cerebral Palsy Association of New York State- East Flatbush

Councilmember Darlene Mealy (cont.)
- Kingsbrook Medical Center
- SUNY Downstate Medical Center- Family Health Services at Lefferts

Councilmember Carlos Menchaca
- Family Physician Center
- Lutheran Family Health Center, Sunset Park/Park Ridge
- Maimonides Medical Center
- Park Ridge Family Health Center
- Brooklyn-Chinese Family Health Center

Councilmember Rosie Mendez
- Sidney Hillman Health Center- Institute for Family Health
- Community Healthcare Network
- Housing Works, Keith D. Cylar House- East Side
- Phillips Ambulatory Care Center
- Beth Israel Medical Center-Phillips Ambulatory Care Center
- Comprehensive Development Inc.

Councilmember I. Daneek Miller
- Jamaica Hospital Medical Center- St. Albans
- Queens Hospital Center (HHC)

Councilmember Annabel Palma
- Montefiore Medical Group-Bronx East
- Bronx Center for Rehabilitation
- Diallo Medical Center
- Institute for Family Health-Parkchester
- Jessica Guzman Medical Center
- Soundview Health Care Network

Councilmember Donovan Richards
- Queens Nassau Rehab & Nursing Center
- Horizon Care Center
- Joseph P. Addabbo Family Health Center-Beach Channel Drive

Councilmember Antonio Reynoso
- CABS Health Center
- Williamsburg Health Center

Councilmember Ydanis Rodriguez
- Audobon Primary Care Practice
- Columbia University College of Dental Medicine
- Dyckman Clinica De Las Americas
- New York Presbyterian Broadway Practice
- NYP Washington Heights Family Center
- Washington Heights Health Center

Councilmember Deborah Rose
- Cerebral Palsy Association of NYS
- Koicheff Healthcare Center
- Staten Island Physician Practice
- Bay Street Health Center
- Beacon Christian Community Health Center
- Community Health Center of Richmond

Councilmember Deborah Rose (cont.)
- Harbor Terrace
- Lakeside Manor Home
- Mariner's Habor Family Health Center
- New Brighton Family Health Center
- Sts. Cosmas & Damian Home

Councilmember Helen Rosenthal
- Institute for Family Health

Councilmember Ritchie Torres
- Care Integration Program
- St. Barnabas Hospital
- Fordham Tremont- East 188th St.- Care Integration Program & Men & Military
- Fordham Tremont- Ryer Ave.- Forensic Services & Mental Illness Chemical Abuse
- Union Community Health Center
- Comprehensive Care Management Corporation at Allerton Ave.
- Bronx Community Health Network
- School Based Program: PS 85
- Montefiore Family Health Center
- Montefiore Medical Group
- Saint Barnabas Ambulatory Care Center
- School Based Program: PS 205
- School Based Program: PS 32
- Union Community Health Center
- Brief Care
- Rev. David Dacella Childrens Services

Councilmember Mark Treyger
- Comprehensive Care Management Corporation at Mermaid Ave.
- Ida G. Israel Community Health Center
- Mermaid Home for Adults
- Oceanview Manor Home
- Sea Crest Health Care Center
- Century Medical & Dental Center

Councilmember James Vacca
- Calvary Hospital
- Montefiore Comprehensive Family Care Center
- Premier Healthcare- Pelham Bay
- Providence Rest
- Throgs Neck Extended Care Facility
- Jacobi Medical Center

Councilmember Jimmy Van Bramer
- Long Island City Health Center
- NYC Dept of Health & Mental Hygiene-Bureau of Health Care System Readiness
- Office of Emergency Preparedness & Response

Councilmember Mark Weprin
- Parker Jewish Institute for Health Care & Rehabilitation

Councilmember Jumaane D. Williams
- Caribbean-American Family Health Center
- Premier Health Care-Bedford

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Center for Court Innovation Testimony
New York City Council
Committee on Health Preliminary Budget Hearing
March 23, 2015

Good afternoon Chair Johnson and distinguished Members of the Council. My name is Courtney Bryan, and I am the Director of Criminal Justice Operations at the Center for Court Innovation. Thank you for giving me the opportunity to speak today.

I am here to urge the Committee on Health, as they are considering the Mayor's proposed budget, to support funding for the Center for Court Innovation as we continue to develop new and innovative public health approaches to reduce violence and aid victims of trauma with mental health needs who are caught within the criminal justice system.

At the Center for Court Innovation we firmly believe that public health is directly linked to violence reduction and community well-being. The epidemic of gun-violence afflicting certain New York City neighborhoods is similar to the outbreak of any other disease and needs to be treated as such, with education and action. In response, the Center's anti-gun violence initiative, Save Our Streets, has been implemented in Crown Heights, Bed-Stuy, and the South Bronx to enact change by modifying community norms and spreading the message that gun-violence is not OK. To spread this message, Save Our Streets, uses "credible messengers," to perform outreach and conflict mediation directed towards individuals at high risk for future gun violence, as well as community mobilization and public education efforts throughout the target community. Educational efforts that include tireless team canvassing on the streets and large scale events like the Healthy Lives/Healthy Communities Resource Fair designed to engage residents in a conversation around the importance of healthy lifestyles and how public health and violence reduction are linked. All of these combined efforts have resulted in a sustained significant decrease of shootings in Crown Heights since its launch in 2010 and 192 days and counting since their last shooting incident in Bed-Stuy.

A study issued in 2012 by The Council of State Governments found that defendants with mental health needs comprise over one third of inmates in New York City Department of Correction Custody, with the number growing. In response, through the partnerships of multiple government agencies, the Court-Based Intervention and Resource Team (CIRT) was developed and implemented in each of the five boroughs. In Brooklyn, the Center for Court Innovation serves as the CIRT provider to offer alternative to detention options including psychiatric and treatment services for individuals with diverse mental health needs. Following CIRT, in 2013, New York State Chief Judge Jonathan Lippman, announced the launch of the New York State court system's Human Trafficking Intervention Initiative with the hopes of bringing a more trauma focused approach to aid individuals with mental needs arrested for prostitution. This initiative, provided by three Center projects, Bronx Community Solutions, Midtown Community Court and Brooklyn Justice Initiatives, ensures that individuals caught in the cycle of exploitation and trafficking are treated as *victims* and not as criminals. Instead of jail time, Center project clinicians identify and address each person's complex needs and shape a plan to stop the cycle of re-arrest and re-victimization. And, in Crown Heights, our program Make It Happen, also uses a trauma informed approach to provide supportive services for young men of color who have been negatively impacted by community violence. Make It Happen provides mentorship, intensive case management, clinical interventions, and supportive workshops so our participants are able to recognize and process their own trauma and get back on the right track towards healthy and productive lives. A justice system focused on the mental health needs of individuals suffering from the negative impacts of trauma has never been clearer and it's an approach that we hope will continue to expand.

The Council's support has been invaluable to the success of the Center for Court Innovation, helping us maintain core operations and launch new initiatives at our demonstration projects throughout New York City. This year, the Center for Court Innovation is seeking the City Council's support in the amount of $775,000 – $400,000 to continue the Center's core work to reduce violence and aid victims of trauma, and an additional $375,000 to support critical new

initiatives focused on youth diversion, police-youth-community relations, and enhanced access to equal and fair justice for the city's most vulnerable citizens.

- Earlier this month, we launched Project Reset together with the NYPD and the District Attorney's Offices in Manhattan and Brooklyn. Project Reset is an early diversion pilot in Brownsville and East Harlem that will divert 16- and 17-year-olds arrested for minor non-violent offenses to counseling or community service before they ever come before a judge – avoiding any chance of a criminal record or time in jail. This is a fundamental shift in the way that law enforcement approaches minor offending, and with the council's help, we hope to expand this critical initiative to many additional precincts and young people around the city.

- In Red Hook, our Peacemaking program seeks to empower an isolated, historically underserved community with high rates of justice system involvement to play an active role in solving its local problems by using traditional Native American techniques. Poverty Justice Solutions, a recently launched new program, will help low-income New Yorkers preserve their housing and prevent homelessness by recruiting law school graduates to serve two year fellowships working in housing courts throughout New York City, greatly increasing tenant access to legal counsel. With the Council's support, we hope to expand these new programs and initiatives that increase procedural fairness, increase access to representation, and engage communities in local problem-solving.

- Finally, at the Brownsville Community Justice Center, police-youth-community dialogues are regularly convened. These unscripted conversations among teens, cops, and residents have helped to not only build trust and understanding, but advance common goals. In Staten Island, a new program, the Neighborhood Youth Justice Council, enables young people, together with other community members and justice stakeholders, to design and implement projects and not just *talk* about police-community dynamics, but actually create positive change. With the Council's help, we hope to expand our police-youth dialogue work to all of our Youth and Community Justice Centers and create

Neighborhood Youth Justice Councils in Jamaica Queens, East Harlem, and other communities.

The Center for Court Innovation looks forward to continuing to work with the New York City Council to create stronger, healthier neighborhoods, aid victims of trauma with mental health needs and improve the overall health and well-being of all New Yorkers. We respectfully urge you to continue to support our work and thank you again for the opportunity to speak. I would be happy to answer any questions you may have.

cphs*
*putting the public back in public health

ACCESS HEALTH NYC
COMMUNITY IS THE KEY

March 23, 2015

Testimony prepared by

Anthony Feliciano

for the

City Council Committee on Health Preliminary Budget Hearing FY 16

on

Access Health NYC & other public health priorities

on behalf of the

People's Budget Coalition for Public Health

Introduction

Good Afternoon and thank you, Chairperson Johnson and members of the Health Committee. My name is Anthony Feliciano and I am the Director for the Commission on the Public's Health System. CPHS appreciates the opportunity to present testimony today to the City Council about ensuring access to coverage and public health programs and services, especially for underserved communities by supporting existing initiatives and building capacity for new initiatives. We co-lead the People's Budget Coalition for Public Health with our partner Federation of Protestant Welfare Agencies.

First, CPHS thanks the city council and mayor's administration for your continued commitment to addressing issues of poverty and those inequities associated with where people live, work, play, interact, and access needed services and programs.

The People's Budget Coalition for Public Health is an alliance of 15+ community and labor organizations united around preserving and expanding our city's public health programs and services. We believe that improving health status, insurance coverage, and access to services can best be accomplished through a community health planning approach. This has been a customary practice and core function of public health. However, the missing piece has been the direct involvement of those who are directly impacted by those policy decisions. The community and health care workforce should be the driving and leading force in the process.

Our Health Priorities and Ideas

1. Fund 5.5 million for Access Health NYC

CPHS would define health care access as a right to contact, enter, exit, communicate with, or utilize health services and programs. Equitable access recognizes that things like geography, preferences, beliefs, communication and comprehension, styles; signage, physical lay-out and service-delivery style influence a person's access to health services and programs. Those program and services must reflect an individuals or communities way they name and understand their reality. Many called that being culturally competent.

One important way we can address problems with equitable access is by supporting Access Health NYC. This new $5.5 million budget initiative request would fill the gaps left by federal health care reform (ACA) and connect all New Yorkers to health care. We like to thank Councilmember Johnson for working closely with the People's Budget Coalition and championing this initiative.

Primary barriers to health and health care for the general population are beginning to be well documented, and heightened awareness of these obstacles has spurred numerous proposals for improving the health care system. Today, other PBC members and Access Health NYC supporters will cite some of these numerous barriers New Yorkers face in accessing health care and coverage. Together we will demonstrate why the initiative's tagline" Community is Key" is the essential ingredient in Access Health NYC potential to make a collective and positive impact. Access Health NYC will

1. Support community based organizations with the goal of targeting individuals and families, who are uninsured, speak English as a second language, people with disabilities, LGBTQ, formerly incarcerated, homeless, and other New Yorkers experiencing barriers to health care access/information about health coverage and options.

2. Create a stronger coordinated and collaborative community-based infrastructure to improve coverage and access to services and programs.

3. Address a resource gap for NYS-funded navigators. Community-based organization could use the funds to hire an additional staff person to work with the Navigator and focus on outreach and linking hard-to reach and underserved New Yorkers to existing free and low cost health care options and the consumer assistance helpline operated by the Community Service Society, which has demonstrated its importance with the high volume of usage and making a difference in ensuring issues are addressed around coverage and navigating services.

There are key New York City neighborhoods and populations that need Access Health NYC These neighborhood include: Jackson Heights, Corona, Elmhurst, Rockaways in Queens; Almost all of the Bronx; Washington Heights in Manhattan; Sunset Park, Williamsburg, Central

and East Brooklyn, and Coney Island in Brooklyn; Northern part of Staten Island. These neighborhoods average an uninsured rate between 16% to over 30%. See enclosed map provided by CPHS and the SAVI program at Pratt Institute. Included is a chart of uninsured data provided by FPWA. These maps use the 5-year estimate from 2009-2013, the latest available 5-year data from the American Community Survey (ACS). Since post ACA, we are aware that these numbers would reflect different percentages once the newest ACS data is released. However, the need is still urgent and not just for the neighborhoods mentioned. It is not coincidental that these very same neighborhoods have populations that remain excluded from ACA. There are populations hidden in other part of the city due to immigration status and often gentrification. Access Health NYC would also help target those hard-to reach populations. For example:

People coming out of the jail and prison system could also benefit from this initiative. 59% of releases interviewed in a report released by Health People, Inc. indicated that they did not have an insurance card on leaving prison.

Information remains limited, but people with disabilities experience both health disparities and specific problems in gaining access to appropriate health care, including health promotion and disease prevention programs and services. They also frequently lack either health insurance or coverage for necessary services such as specialty care, long-term care, care coordination, prescription medications, durable medical equipment, and assistive technologies.

We don't expect an initiative like Access Health NYC to solve these types of barriers. We need much more robust and community driven reforms to do that. However, Access Health NYC would play an important bridge to help people access the appropriate coverage and care, know their rights when accessing care, and meet their needs in a trusted and culturally competent matter, which only local community-based organization can provide.

Cultural competence factor is important part of Access Health NYC because:

- It reduces disparities in health services and increases detection of culture specific diseases.
- It addresses inequitable access to primary health care.
- It impacts health status of culturally diverse communities.
- It responds to New York City's changing demographics – an increasingly diverse population

$5.5 million will support lead agencies to fund, train, monitor/evaluate, and provide technical assistance/ guidance to local CBO's as well as support a consumer helpline. As a coalition we have agreed that the if funding was made available, the lead agencies would be Coalition for Asian American Children and Families, Commission on the Public's Health System, Community Service Society, Federation of Protestant Welfare Agencies, and the New York Immigration Coalition. **Attached is the draft scope of work that divides the tasks and roles.**

2. Other Initiatives that address health disparities

People of color and other medically underserved populations face barriers to obtaining quality care. These populations are more likely to suffer from chronic conditions, lack insurance, and remain untreated for conditions that will continue to deteriorate without attention. We support investment in following programs and efforts to end health disparities and improve our city's wellness.

- The DOH is rightly investing in increasing breastfeeding and family planning among low-income women in NYC. However, we have been troubled by the lack of information from the NYCDOHMH about how Infant Mortality Reduction Initiative (IMRI) will roll out this fiscal year. Although, IMRI was base-lined in the city budget, the city DOH was delayed with the new contracts and delayed the funds that were part of last fiscal year's contracted services to community based organization in the IMRI. Both investments should be seen as mutually benefiting and strengthening each other.

- Healthy Women, Healthy Futures- would scale up efforts in addressing the dramatic and persistent health disparities in maternal and infant health. In 2002, the City launched the Infant Mortality Reduction Initiative (IMRI) to address these disparities in infant health outcomes, and with significant effort, the infant mortality rate has continued to drop. Following these successes in infant health, there has been a renewed recognition of the dire need for efforts targeted to improving maternal health. Our understanding that the Healthy Women, Healthy Futures program will focus only on expanding access to birth and postpartum doula. The program originally would dedicate $2 million to pre- and inter-conception care programs for women before and between pregnancies. We would expect the following from the DOH:
    - To also fund the pre and inter-conception care portion of the proposal
    - To ensure that the doula portion utilizes a community health worker model of practice. There needs to be attention placed to training of doulas with the lens of ensuring cultural competence, especially if they can be trained and hired from communities suffering the greatest disparities in maternal and infant care indicators.

- $8.2 million for new community-based health clinics: DOHMH new community health hubs located in or near the three existing District Public Health Offices (DPHO's) in Tremont, East Harlem and BedStuy as well as southwestern Queens. These hubs will provide physical space in DPHO's buildings for co-location of community-based organizations, NYC government agencies, and providers of medical services and primary care, which include Article 28/Diagnostic and Treatment Centers (DTCs), and Federally Qualified Health Centers (FQHCs),

- $749,000 for an annual child health survey, which will enhance the City's capability to monitor and evaluate trends in child health risk factors and outcomes: This is critical to getting a more accurate picture of the health of children in NYC. The data could be useful to child health advocacy efforts to improve and better integrate social and public health programs and services.

- $1.06 million for a Language Development Campaign, which is a media campaign to encourage parents of young children to talk, read, and sing to their babies to promote brain development: This is tremendous win for addressing prevention in mental health. We would hope the city's Department of Health will invest in outreach efforts and not solely advertisements. In the past, the DOH has focused lots of resources in advertising. We feel that would be different with the new leadership at the DOH.

- We support the charge for a new mental health initiative headed by First Lady Chirlane McCray. In 2008, CPHS released a report on access and quality of care for children and families as part of celebrating 100 years of the Child Health Clinics. In that report, surveys results and focus group responses still remains true today, that providing quality of care and resources to help vulnerable communities' access mental health services was critical. Many teens, especially in the Bronx lack access to mental health services. Link to report: http://www.cphsnyc.org/cphs/reports/december_2008-_voices_from_the_c/. With the mayor's administration recognizing the importance of addressing mental health, we want to make sure that $200,000 remain in the budget for the mental health services under 5 initiatives.

3. Privatization of our public health resources

We oppose the further privatization of dialysis at Lincoln, Harlem, Metropolitan and King's County Hospitals. Big Apple Dialysis Management, the for-profit company has bided to take over dialysis centers at these four city's public hospitals. The Big Apple deal is rotten because:

• 25% of Big Apple facilities have death rates the government calls "worse than expected". • Big Apple's are among the worst facilities in the USA. • Big Apple will make millions of dollars a year on these clinics.

Furthermore, we are deeply troubled by HHC's plans to extend the contract with Sodexo by ten years to provide the management of the Cook Chill Plant, equipment, food and supplies. Sodexo has proven to mistreat union workers and have failed satisfaction surveys.

4. Other asks

1. The Mayor's administration must stop the privatization of dialysis by telling HHC to pull the contract with Big Apple.

2. The city council should explore the creation of a taskforce to expand dental care- Despite high rates of coverage, many New Yorkers lack adequate access to oral health services. According to a NYC DOHMH report in 2012, nearly one quarter of New York City children did not have a preventive dentist visit within the past year. Nearly a third of all adults did not see a dentist in the past year. This service gaps grows more pressing when viewed for through the lens of racial and ethnic health disparities. Proper oral health services are deeply needed as a means for detecting greater threats to whole body health.
3. City Council need to pass the Asthma-free Homes legislation, which seeks to reduce indoor allergen hazards than can trigger asthma in residential dwellings.
4. Partner with local and citywide CBO's, including CPHS to ensure The DSRIP program will bring true integration and coordination to the health care system. DSRIP is the largest part of the State's version of a Medicaid waiver, totaling $8 billion dollars over a five-year period. The major goal of the DSRIP ($6.2 billion) portion of the waiver is to reduce unnecessary hospitalizations and Emergency Room visits by 25% over five years. These dollars will primarily go to the hospitals that have formed coalitions (10 currently applying from the city). The Mayor, Speaker, and City Council can work with advocates to hold public hearings focused on two areas: Community engagement and contracting; and the finances that would be utilized by the hospital coalitions.

Fund ACCESS HEALTH NYC to ensure that the most underserved New Yorkers will be informed about their rights and options in accessing health care services and programs

ACCESS HEALTH NYC

COMMUNITY IS THE KEY

A Grassroots Advocacy Campaign of the People's Budget Coalition for Public Health

What is ACCESS HEALTH NYC?

- Access Health NYC is a city-wide proposal to fund community-based organizations (CBOs) to provide education, outreach, and assistance to all New Yorkers about how to access health care and coverage.
- Access Health NYC will build capacity, amplify existing community-based efforts, and support community based organizations with the goal of targeting individuals and families, who are uninsured, speak English as a second language, people with disabilities, LGBTQ, formerly incarcerated, homeless, and other New Yorkers experiencing barriers to health care access/information about health coverage and options.
- Access Health NYC enhances the work of the NYS-funded navigators by informing and linking hard-to reach and underserved New Yorkers to coverage and existing free and low cost health care options and to provide consumer assistance.

Why do we need ACCESS HEALTH NYC?

- Health care is complicated in New York. Many communities do not know how to access the many sources of free and low-cost care, including knowing their rights when accessing health care services.
- Underserved communities look to CBOs for culturally competent and accurate information about public programs and services. CBOs need funding, support and training to help them ensure that every New Yorker understand how to access health care coverage and services.
- Better access to insurance coverage and primary and preventive care will reduce health care costs for families and safety net providers like HHC, and improve health outcomes for all New Yorkers.
- New York State of Health Navigator contracts do not fund navigator organizations to conduct community education, outreach and post-enrollment assistance.

How will ACCESS HEALTH NYC work?

- **$5.5 million** will support lead agencies to fund, train, monitor/evaluate, and provide technical assistance/ guidance to local CBO's as well as support a consumer helpline. Lead agencies are Coalition for Asian American Children and Families, Commission on the Public's Health System, Community Service Society, Federation of Protestant Welfare Agencies, and the New York Immigration Coalition.
- Close to 80% of the **funds will be re-granted to CBO's** to conduct 10 provider training events each and support 30 targeted education and outreach events throughout the city and to provide consumer assistance to New York City residents.
- Key grants allocation criteria: number of uninsured, newly insured, and identified gaps/barriers in neighborhoods to culturally and linguistically competent care.

Sponsoring organizations:

CACF

nyic NEW YORK IMMIGRATION COALITION

cphs *putting the public back in public health

FPWA

Community Service Society | Fighting Poverty Strengthening New York

For more info, please contact:

- Claudia Calhoon at ccalhoon@thenyic.org
- Anthony Feliciano at afeliciano@cphsnyc.org
- Esther Lok at esther@fpwa.org
- Noilyn Abesamis-Mendoza at namendoza@cacf.org
- Nora Chaves at nchaves@CSSNY.ORG
- Or call CPHS at 212-246-0803

Fund ACCESS HEALTH NYC to ensure that the most underserved New Yorkers will be informed about their rights and options in accessing health care services and programs

Organizational Supporters (in formation)

Academy of Medical & Public Health Services
Adhikaar
Advocate for the Learning Disabled
American Heart Association
Arab-American Family Support Center
Brooklyn Center for Independence of the Disabled
Brooklyn Perinatal Network
Bronx Health Link
Cabrini Immigrant Services
CAMBA
Center for Independence of the Disabled, NY
Children's Defense Fund-New York
Christopher Rose Community Empowerment Campaign
Cidadão Global
Choices in Childbirth
Citizens' Committee for Children
Coalition for Asian American Children and Families
Commission on the Public's Health System
Community Service Society of New York
Cypress Hills Local Development Corporation
Diaspora Community Services
District Council 37
Doctor's Council SEIU
Federation of County Networks, Inc
Federation of Protestant Welfare Agencies
Fort Greene SNAP
Gay Men's Health Crisis
Greater Brooklyn Healthcare Coalition
Greater NYC for Change
Health & Hospitals Corporation
Healthy People
Housing Works
Immigrant Health and Cancer Disparities Service –
Korean Community Services of Metropolitan NY
Latinos for Healthcare Equity
MSKCC
Institute for the Puerto Rican Hispanic Elderly
Japanese American Association of New York
Japanese American Citizens League, NY Chapter
Local 1180 - Communications Workers of America
Make the Road-NY
Manhattan-Staten Island Area Health Education Center
Mekong NYC
Metro New York Health Care for All Campaign
MyTime Inc
New Immigrant Community Empowerment
New York Committee for Occupational Safety and Health (NYCOSH)
New York Immigration Coalition
New York Lawyers for the Public Interest
New York State Nurses Association
Northern Manhattan Perinatal Partnership, Inc.
NYSED - ACCES-VR Queens District Office
NYU Center for the Study of Asian American Health
Planned Parenthood of New York
Peter Cicchino Youth Project of the Urban Justice Center
Physicians for a National Health Program (PNHP)-NY Metro Chapter
Polonians Organized to Minister to Our Community (POMOC)
Raising Women's Voices NY
Restaurant Opportunities Center of New York (ROC-NY)
SCO Center Family Life
Sapna NYC
SEEDCO
South Asians For Empowerment (SAFE)
South Asian Council for Social Services
Spanish Speaking Elderly Council- RAICES
SustyQ (Sustainable Queens)
United Chinese Association of Brooklyn, Inc
United Neighborhood Houses
UNITED SIKHSVillage Care
VISIONS/Services for the Blind and Visually ImpairedWilliam F. Ryan Community Health Center
YWCA of Queen
32 BJ- SEIU
116th Street Block Association,Inc

New York City Uninsured Populations by City Council District (American Community Survey, 2009-2013)

ACCESS HEALTH NYC
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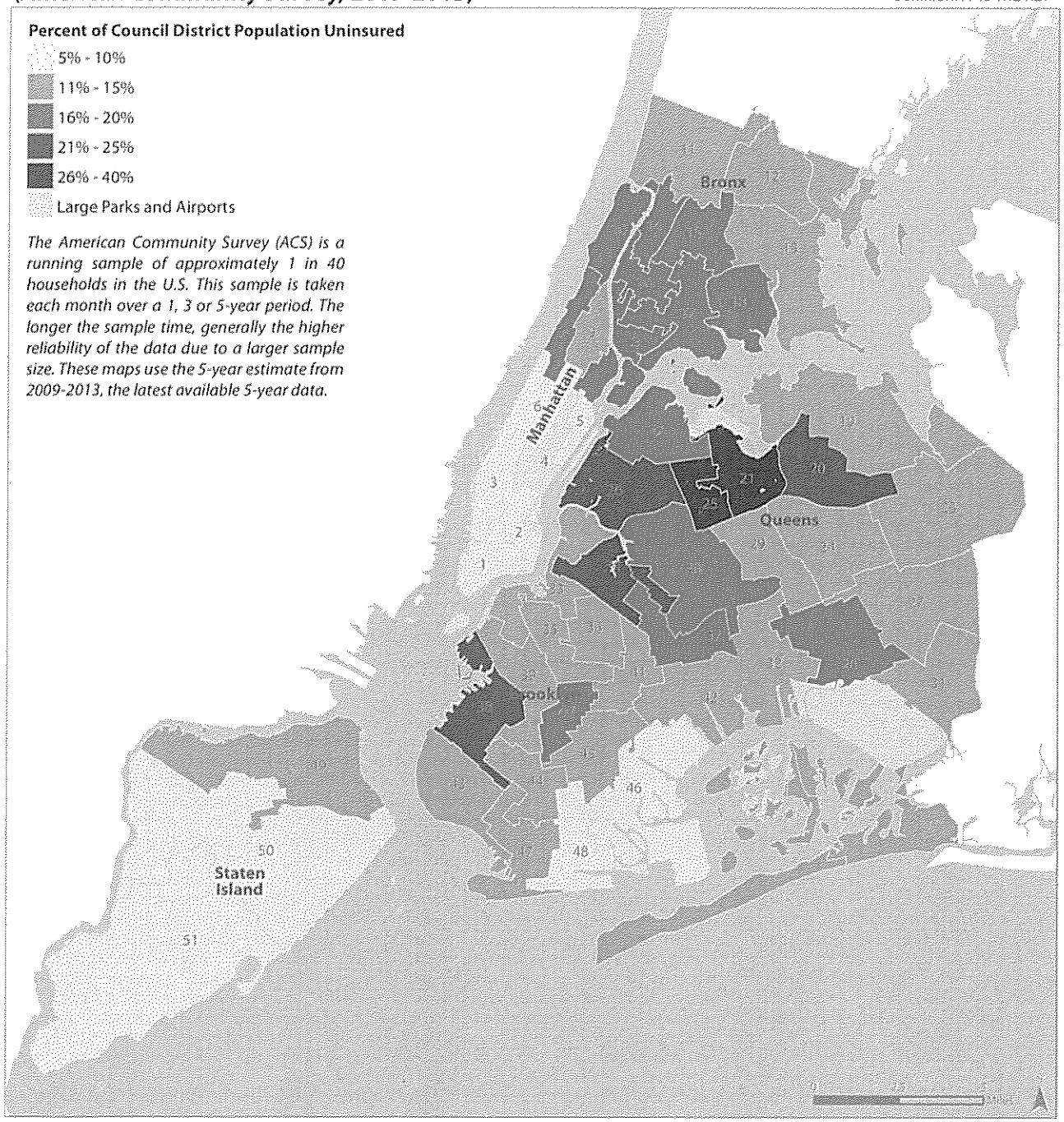

The American Community Survey (ACS) is a running sample of approximately 1 in 40 households in the U.S. This sample is taken each month over a 1, 3 or 5-year period. The longer the sample time, generally the higher reliability of the data due to a larger sample size. These maps use the 5-year estimate from 2009-2013, the latest available 5-year data.

cphs*
*Putting the public back in public health

Made for the People's Budget Coalition for Public Health.

Sources: NYC DCP, NYC DPR, NJ DEP, NYS CSCIC
2009-2013 American Community Survey.
2/12/15.

SAVI
Spatial Analysis and Visualization Initiative

New York City Populations Speaking Languages other than English or Spanish by Zip Code (American Community Survey, 2009-2013)

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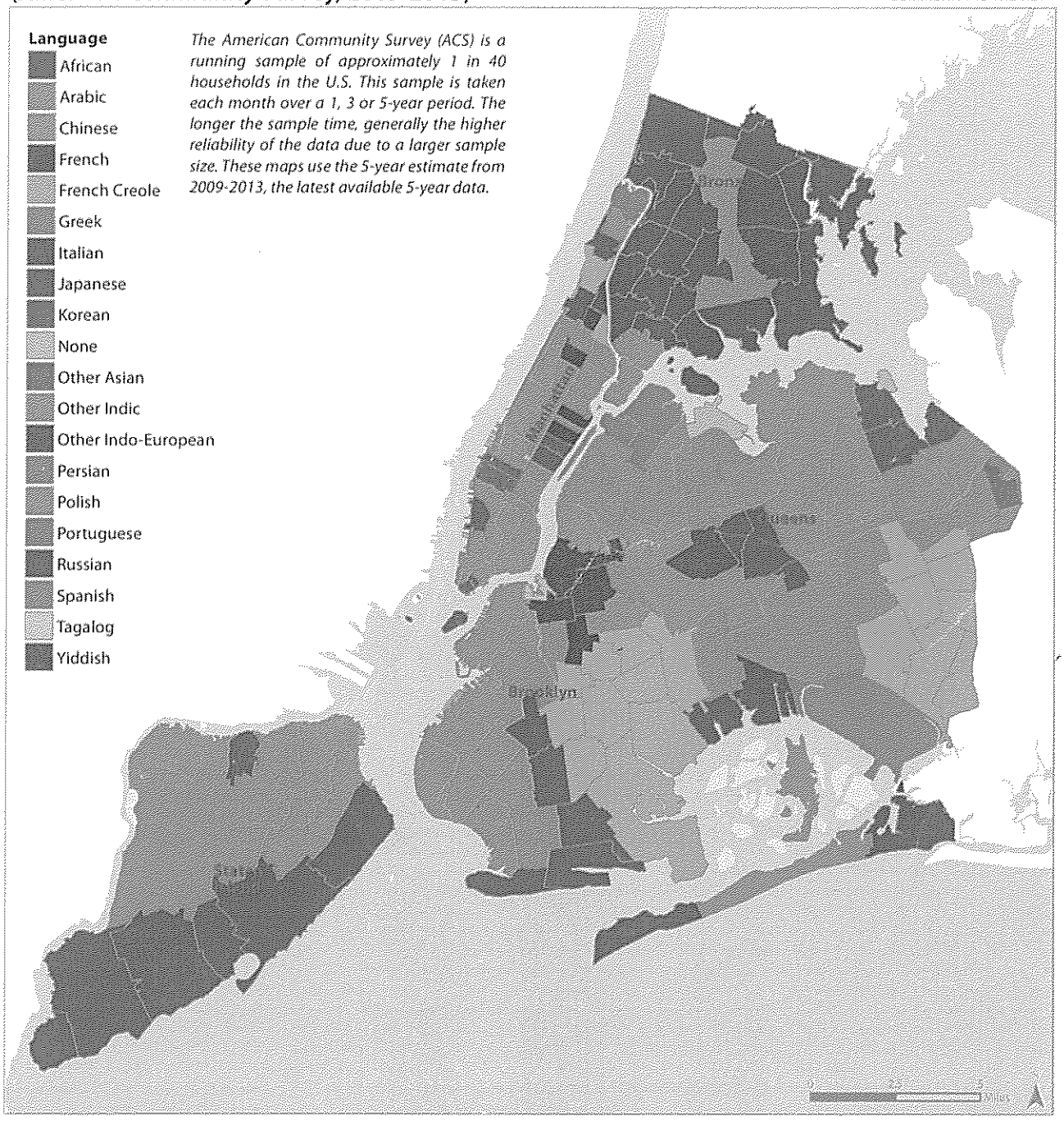

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Made for the People's Budget Coalition for Public Health.

Sources: NYC DCP, NYC DPR, NJ DEP, NYS CSCIC
2008-2012 American Community Survey.
11/17/14.

SAVI
Spatial Analysis and Visualization Initiative

New York City Populations with Disability and without Insurance by Census Tract (American Community Survey, 2009-2013)

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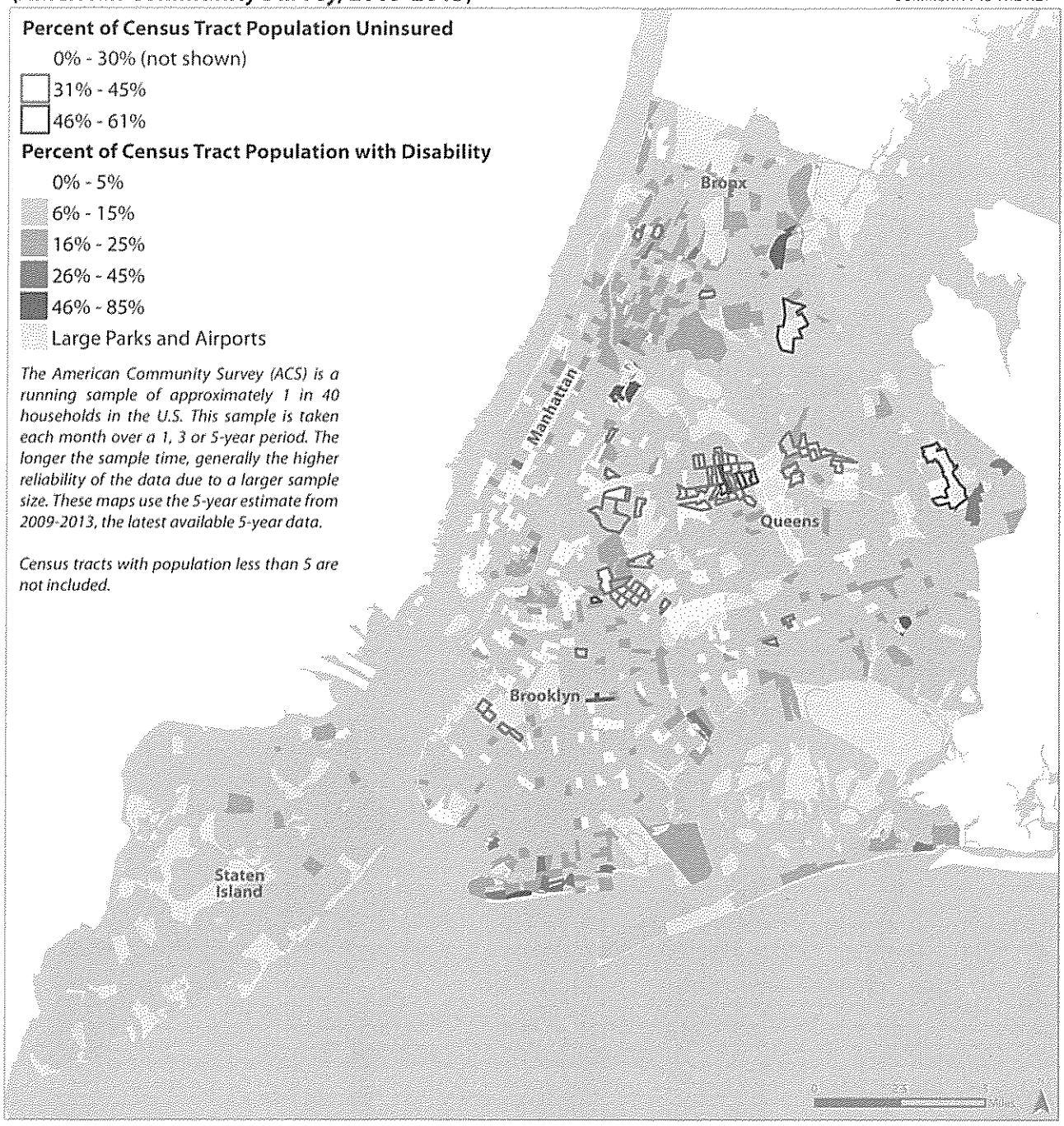

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Made for the People's Budget Coalition for Public Health.

Sources: NYC DCP, NYC DPR, NJ DEP, NYS CSCIC
2009-2013 American Community Survey.
03/03/2015.

SAVI

New York City Uninsured Population and Small Businesses with less than 50 Employees by Zip Code

ACCESS HEALTH NYC
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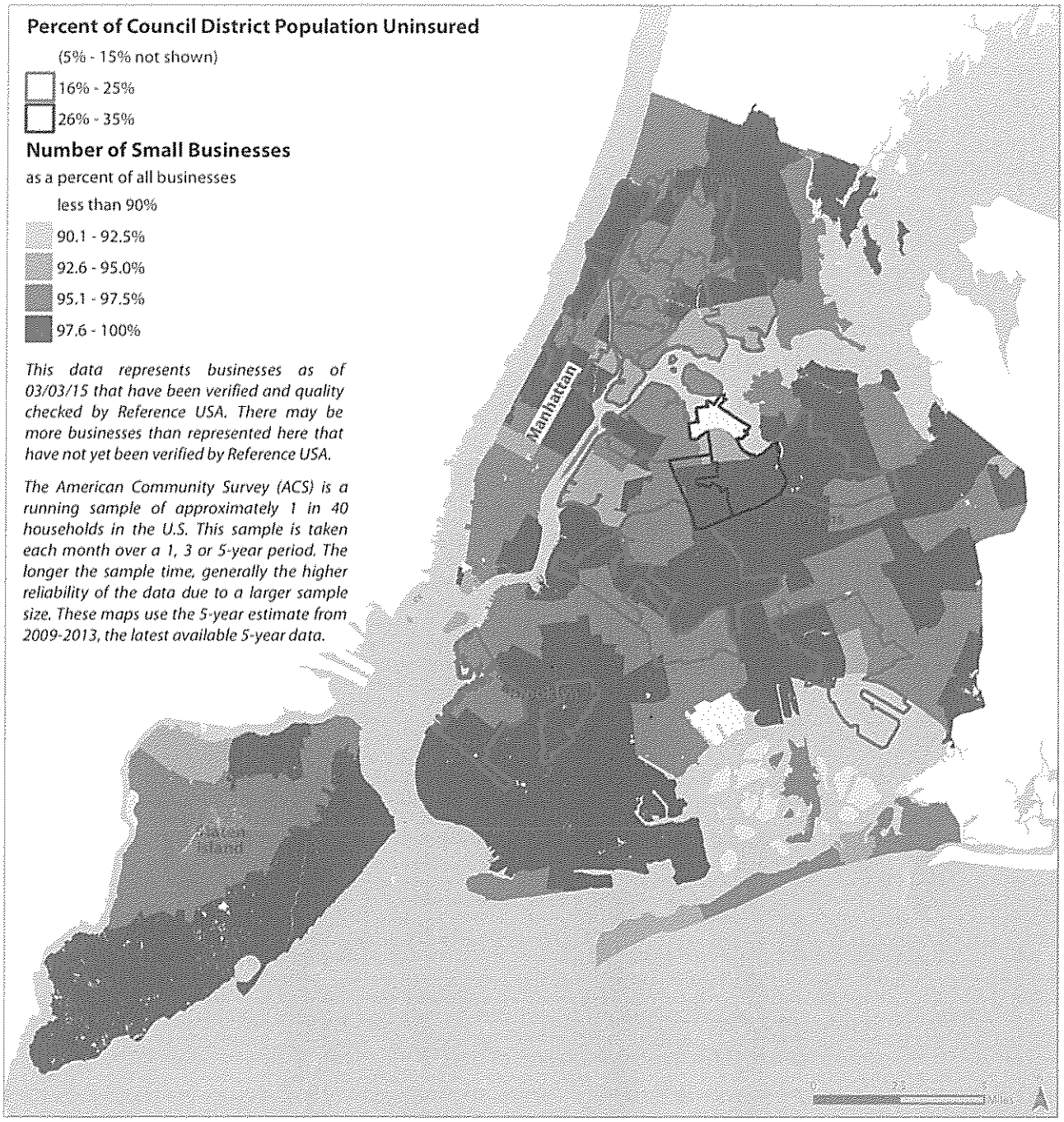

This data represents businesses as of 03/03/15 that have been verified and quality checked by Reference USA. There may be more businesses than represented here that have not yet been verified by Reference USA.

The American Community Survey (ACS) is a running sample of approximately 1 in 40 households in the U.S. This sample is taken each month over a 1, 3 or 5-year period. The longer the sample time, generally the higher reliability of the data due to a larger sample size. These maps use the 5-year estimate from 2009-2013, the latest available 5-year data.

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*Putting the public back in public health

Made for the People's Budget Coalition for Public Health

Sources: Reference USA, NYC DCP
ACS 2009-2013

03/03/15

SAVI
Spatial Analysis and Visualization Initiative

ACCESS HEALTH NYC
COMMUNITY IS THE KEY

Fund ACCESS HEALTH NYC to ensure that the most underserved New Yorkers will be informed about their rights and options in accessing health care services and programs

Scope of Work

This document outlines the proposed division of labor for the outreach, education and health consumer assistance program Access Health NYC, an initiative proposed by the People's Budget Coalition for Public Health (PBC). This scope of work was developed in collaboration with the coalition members and supporters and is provided as a companion piece to the one-page description of the initiative. The leadership structure proposed reflects our commitment to horizontal and collaborative decision-making. Should PBC receive initiative funding in Fiscal Year 2016, the components will require additional discussion and may change. We believe that an initiative of this magnitude and scope will only succeed if we learn and share experiences in helping hard to reach populations understand their options to accessing health care services to course correct, adjust messaging and remain flexible.

Description:
The Access Health NYC Initiative target individuals and families, who are uninsured, newly insured, speak English as a second language, people with disabilities, LGBTQ, formerly incarcerated, homeless, and other New Yorkers experiencing barriers to health care access/information about health coverage and options.

This citywide initiative addresses the lack of resources to build capacity for culturally and linguistically appropriate education and outreach efforts in our existing health care system. It will support community-based organizations (CBOs) that understand and appropriately address the culture and language needs of hard-to-reach communities by providing them with training and technical assistance. Access Health also complements and enriches the work of the NYS-funded navigators by informing and linking hard-to reach and underserved New Yorkers to coverage and existing free and low cost health care options. It provides valuable consumer assistance for those that are having difficulties using low-cost care options and/or insurance.

To successfully reach diverse, multi-language New Yorkers, NYC needs an aggressive outreach and public awareness initiative that complements existing pre- and post- enrollment efforts by supporting community-based organizations (CBOs) to:

1. **Promote maximum reach to individuals and families having difficulty accessing coverage and care options by:**

    - Building on existing resources and networks with stakeholders with common missions and visions
    - Conducting outreach to populations that are eligible for insurance as well as those who have limited coverage options based on their immigration status
    - Establishing a trusted program that reflects the cultural and linguistic diversity of NYC
    - Developing successful partnerships among New York State of Health Navigator organizations and non-navigator organizations

2. **Increase opportunities to learn on how to navigate the health care system by**

- Informing CBOs about New York State's protections for health consumers and equip CBOs to effectively communicate this to the communities to which they provide services
- Helping newly enrolled New Yorkers understand complex health insurance terms, how to use their new coverage, and to assist them with resolving disputes or filing appeals.
- Learning from participating CBOs and adjusting strategies and tactics based on ongoing feedback, research, evaluation and measurement of program impact

Proposed Methodology for Distribution of Funds: Reflecting the diverse organizational expertise of PBC and its partners, we envision a coordinated approach between four lead organizations listed below, that will work on sub-award administration, training, technical assistance, and reporting and develop a system for these major components to effectively link with each other.

- **Administrative and Re-grant to CBOs: Coalition for Asian American Children and Families (CACF)** CACF will be responsible for re-granting to CBOs for health outreach and education. It will be responsible for developing and executing the re-granting application process and procedures, establishing the allocations panel, allocating the funds to grantee CBOs and coordinating with the contracting agency. Through network meetings, conference calls and webinars, CACF will work with collaborative partners to ensure programs operated by grantee CBOs successfully implement agreed upon activities in neighborhoods of large uninsured and newly insured populations. It will work with grantees CBOs on their deliverables, which will include:

  - Participate in Access Health NYC training events
  - Adapt Access Health NYC templates to be culturally and linguistically appropriate for communities served
  - Conduct presentations, schedule speaking engagements, participate in health fairs
  - Engage media to disseminate accurate information and promote their programming
  - Provide one-on-one consultation and education to individuals seeking information, and referrals to more in-depth health consumer and post-enrollment assistance
  - Follow-up on referrals, troubleshoot, and ensure they utilize the health coverage they receive (e.g. choosing a PCP and scheduling an appointment for a well visit)
  - Develop and maintains networks with federal, state and local agencies, New York City Council members, and community-based partners to determine needs and understand infrastructures for outreach and education
  - Participate or plan events in conjunction with their City Councilmember and other elected officials (at least two public and accessible activities)

  The responsibilities of the Administrative Lead organization will be:
  - Develop RFP criteria (desired allocation of funds: 1/2 navigators and 1/2 non-navigators)
  - Coordinate network meetings, conference calls and webinars
  - Answer inquiries about RFP process and guide potential grantees as they prepare necessary paperwork for the initial vetting process
  - Serve as the administrative liaison between PBC and city funding agency with regards to subcontracts for grantees
  - Recruit and convene allocation committee (grant review committee). Allocation of committee can include a mix of PBC partners and local funders.
  - Create scoring rubric for grant reviews
  - Host informational sessions with PBC leads about RFP process
  - Organize grantee reception
  - Organize orientation to inform grantees about final documentation and financial requirements of subcontract funding disbursements
  - Process subcontract payments to grantees
  - Manage financial reporting related to grantee payments

- **Training, Technical Assistance and Capacity Building: New York Immigration Coalition (NYIC)**
  NYIC will identify, develop, and execute 10 training events and technical assistance for grantees CBOs. NYIC will work with partners to provide technical assistance to grantee CBOs to implement education and outreach events on healthcare access and coverage, using health insurance, and addressing post-enrollment issues for target populations (people with disabilities, immigrants, LGBTQ, formerly incarcerated, homeless and persons who speak English as a second language), families without coverage, and populations that experience barriers to health care access/information about health coverage.

  Training topics to be covered in the trainings will include:

  - Overview of coverage for hard-to-reach populations (people with disabilities, immigrants, homeless, LGBT, re-entry populations, former foster care youth). In designing training modules CBO's will provide feedback on who are the hard-to-reach populations, and on the most critical social, economic, and geographic barriers to accessing coverage
  - Immigration eligibility and concerns regarding access to health care and coverage
  - Health insurance 101
  - Beyond the basics of health insurance (e.g. understanding difficult insurance concepts, balance billing, out-of-network bills, resolving disputes and appeals, special enrollment periods, tax credits and the IRS reconciliation process, and the individual mandate).
  - Behavioral health parity provisions of the ACA
  - Provision of culturally and linguistically competent behavioral healthcare for children in NYC
  - Accommodations and support for populations with disability
  - Overview of public and private health insurances programs (e.g. Medicaid, Medicare, Emergency Medicaid, Affordable Care Act)
  - Where uninsured can access care (HHC Options, Federally-qualified Health Centers)
  - Consumer rights and health care
    - Getting to the hospital – Emergency Medical Services/Discharge.
    - Getting treated in the Emergency Room.
    - Hospital Billing and Financial Assistance Protection
    - Access to Health Care in Your Language
    - Safety Net Health Care Providers
    - Patients Rights & Hill-Burton

  TA and Capacity Building areas:

  - Develop a wide variety of tools for operating an effective outreach and education program, including careful research, targeted mass, social and paid media, public relations; partnerships with a wide array of community, faith, labor, industry, health care, business and other organizations; and simple data collection. TA will be provided via email, phone and conference call in order to resolve barriers for organizations engaged in outreach, education and enrollment assistance.
  - Other TA vehicles will include: Publishing meaningful technical assistance responses, Q&As and other materials to social media, blogs, websites and other venues to grow the member and partner knowledge base.
  - Learning Circles: Periodic meetings convene with all funded CBOs to allow opportunities to troubleshoot, problem solve and develop best practices
  - TA and capacity building topics will include guidance on how to:
  - Employ marketing campaign elements, including paid advertising, ethnic and community media relations, community education/public awareness, grassroots outreach, partnerships, small business outreach, social media, and direct marketing
  - Meet contracting standards and deliverables

- Develop core education materials in different languages for easy adaptation and co-branding and reflective of any disabilities in comprehension of information
- Create health literacy materials and materials appropriate for individuals not literate in their own language
- Develop a strong referral system
- Identify, store, and share data pertinent to citywide initiative and outreach efforts

- **Consumer Assistance: Community Service Society (CSS)**
  CSS will operate a free live-answer helpline to assist consumers seeking health coverage and with using it. Multilingual helpline services will assist consumers with issues such as: understanding how insurance works (e.g. deductibles, co-pays, co-insurance, "metal level" plans, cost-sharing reductions);accessing low-cost care; negotiating bills; submitting prior approvals for specialty and other care; negotiating health plan disputes and appeals for all forms of insurance -- Public, commercial (Marketplace and Job based) union, ERISA plans, Medicare etc...) The helpline will also be available to support Access Health New York City advocates from CBOs on a real-time basis as well as councilmember constituent services staff and other individuals working with consumers to resolve their health care and coverage issues. In partnership with NYIC and others, CSS will help design and provide training and otherwise support grantee CBOs and community partners on all aspects of consumer rights in accessing the health care system, including free and low cost health care and all forms of insurance coverage. CSS will receive referrals from CBOs on complex cases that may need more expertise than what the CBO could offer.

  - Staff a live answer toll-free consumer assistance line would handle up to between 5,000-10,000 consumer assistance cases in multiple languages (Spanish, Russian, Hindi, Urdu, Farsi, and French currently on staff, with language line available for all other callers)
  - Support NYIC and CPHS in training and hosting regular CBO meetings where groups can share experiences, receive training on new and emerging health access topics.
  - Provide webinar trainings for advocates that are unable to travel.
  - Provide technical assistance and content-based mentoring for the network agencies.
  - Work with the other lead agencies and grantees on identifying trends and issues to provide real time feedback to City Council members and other stakeholders about issues in the health care system experienced by their constituents.

- **Reporting: Federation of Protestant Welfare Agencies (FPWA)**
  FPWA will be responsible for developing and implementing the work plan of this collaborative. FPWA will also be responsible for developing and maintaining monthly reporting system of the initiative's metrics, analyzing data, developing quarterly reports, best practices, testimonies and policy briefs, and documenting success stories. FPWA will also be responsible for educating city and state elected and public officials about this initiative and hosts training events.

  Other duties include:
  - Draft meeting summaries, site visit reports, testimonials/stories and best practice.
  - Demographics educated by CBOs, and what the outcomes are including:
    - The number of uninsured people contacted by CBOs
    - The number of people CBOs referred to HHC Options and develop a system to document the impact
    - The number of people CBOs referred to FQHC or other health care setting that meet their needs and whether they utilized the services
    - The number of people and types of help and ways of trouble shooting that CBOs provided
    - The number of people CBOs referred to navigators/and certified application counselors in hospitals
    - The number of outreach and education activities conducted and people attending the activities
    - The number of small business (mom-pop shops, ethnic businesses) contacted
    - The number of resolved and unresolved complaints

FEDERATION OF PROTESTANT WELFARE AGENCIES

Uninsured Data

Manhattan Progressive Caucus Members

Council Member **Chin** (District 1)

Neighborhoods	Lower East Side	Chinatown	SoHo-Tribeca-Little Italy-Civic Center	Battery Park and Lower Manhattan
Population	73746	45019	39922	37501
Uninsured	8081	6119	3317	2203
Percentage	11%	13.6%	8.3%	5.9%

Average Percentage =Total uninsured/total Population
10% uninsured

Council Member **Johnson** (District 3)

Neighborhoods	Clinton	Hudson Yards-Union Square-Chelsea-Flatiron	West Village
Population	42908	68967	67125
Uninsured	5865	6030	3586
Percentage	13.7%	8.7%	5.3%

Average Percentage
8.6%

Council Member **Kallos** (District 5)

Neighborhoods	Lenox Hill-Roosevelt Island	Yorkville
Population	79212	77257
Uninsured	4605	5904
Percentage	5.8%	7.6%

Average Percentage:
6.7%

Council Member **Rosenthal** (District 6)

Neighborhoods	Upper West Side	Lincoln Square
Population	134528	60184
Uninsured	10622	2614
Percentage	7.9%	4.3%

Average Percentage:
6.7%

Prepared By Federation of Protestant Welfare Agencies
Last Updated January 28, 2015

FEDERATION OF PROTESTANT WELFARE AGENCIES

Council Member **Levine** (District 7)

Neighborhoods	Hamilton Heights	Manhattanville	Morningside Heights
Population	51465	23802	55927
Uninsured	10039	4692	4440
Percentage	19.5%	19.7%	8.2%

Average Percentage:
14.6%

Council Member **Mark-Viverito** (District 8)

Neighborhoods	East Harlem North	East Harlem South	West Concourse	Mott Haven-Port Morris
Population	60016	58942	39619	52086
Uninsured	10565	9725	7726	9522
Percentage	17.6%	16.5%	19.5%	18.3%

Average Percentage:
17.8%

Council Member **Rodriguez** (District 10)

Neighborhoods	Washington Heights South	Washington Heights-North	Marble Hill-Inwood
Population	89205	69655	50352
Uninsured	18586	11050	10295
Percentage	20.8%	15.9%	20.4%

Average Percentage:
19%

Bronx Progressive Caucus Members

Council Member **Torres** (District 15)

Neighborhoods	Williamsbridge-Olinsville	Bronxdale	Van Nest-Morris Park-WestChester Square	East Tremont	Claremont-Bathgate	Belmont
Population	60858	33389	29434	41380	30363	25783
Uninsured	9468	6612	5153	7106	4231	4584
Percentage	15.6%	19.8%	17.5%	17.2%	13.9%	17.8%

Average Percentage:
16.7%

FEDERATION OF PROTESTANT WELFARE AGENCIES

Queens Progressive Caucus Members

Council Member **Ferreras** (District 21)

Neighborhoods	East Elmhurst	North Corona	Corona
Population	22980	50295	53644
Uninsured	6849	22090	14978
Percentage	29.8%	43.9%	27.9%

Average Percentage
34.6%

Council Member **Dromm** (District 25)

Neighborhoods	Jackson Heights	Elmhurst	Elmhurst-Maspeth
Population	104869	84806	25088
Uninsured	26293	24731	6737
Percentage	25.1%	29.2%	26.9%

Average percentage
26.8% uninsured

Council Member **Van Bramer** (District 26)

Neighborhoods	Hunters Point-Sunnyside-West Maspeth	Queensbridge-Ravenswood-Long Island City	Woodside
Population	60033	18521	44773
Uninsured	12244	3281	9404
Percentage	20.4%	17.7%	21.0%

Average Percentage:
20.2%

Council Member **Miller** (District 27)

Neighborhoods	St. Albans	Cambria Heights	Hollis
Population	50573	20179	21127
Uninsured	6048	2018	3766
Percentage	12.0%	10%	17.8%

Average Percentage:
12.8%

Prepared By Federation of Protestant Welfare Agencies
Last Updated January 28, 2015

FEDERATION OF PROTESTANT WELFARE AGENCIES

Brooklyn Progressive Caucus Members

Council Member **Richards** (District 31)

Neighborhood	Laurelton	Springfield Gardens South-Brookville	Rosedale	Far Rockaway-Bayswater	Hammels-Arverne-Edgemere
Population	25127	19835	28201	48539	34216
Uninsured	2642	2232	3102	5855	3675
Percentage	10.5%	11.3%	11.0%	12.1%	10.7%

Average Percentage:
11.2%

Council Member **Levin** (District 33)

Neighborhoods	Brooklyn Heights-Cobble Hill	DUMBO-Vinegar Hill-Downtown Brooklyn-Boerum Hill	North Side-South Side	Greenpoint
Population	23498	34719	46039	31508
Uninsured	1250	3366	7323	6478
Percentage	5.3%	9.7%	15.9%	20.6%

Average Percentage:
13.5%

Council Member **Reynoso** (District 34)

Neighborhoods	Williamsburg	North Side-South Side	East Williamsburg	Bushwick South	Ridgewood
Population	32650	46039	33139	70981	70082
Uninsured	1425	7323	5395	14205	16411
Percentage	4.4%	15.9%	16.3%	20.0%	23.4%

Average Percentage:
17.7%

Council Member **Menchaca** (District 38)

Neighborhoods	Carroll Gardens-Columbia Street-Red Hook	Sunset Park West	Sunset Park East
Population	38965	52486	71445
Uninsured	4127	13145	16258
Percentage	10.6%	25.0%	22.8%

Average Percentage:
20.5%

Prepared By Federation of Protestant Welfare Agencies
Last Updated January 28, 2015

FEDERATION OF PROTESTANT WELFARE AGENCIES

Council Member **Lander** (District 39)

Neighborhoods	Carroll Gardens-Columbia Street-Red Hook	Park Slope-Gowanus	Windsor Terrace	Kensington-Ocean Parkway
Population	38965	72707	22563	36020
Uninsured	4127	7371	1812	5626
Percentage	10.6%	10.1%	8.0%	15.6%

Average Percentage:
11.1%

Council Member **Williams** (District 45)

Neighborhoods	East Flatbush-Farragut	Erasmus
Population	52647	29894
Uninsured	6961	6050
Percentage	13.2%	20.2%

Average Percentage:
15.7%

Staten Island Progressive Caucus Member

Council Member **Rose** (District 49)

Neighborhoods	Mariner's Harbor-Arlington-Port Ivory-Graniteville	Port Richmond	Westerleigh	West New Brighton-New Brighton-St.George	New Brighton-Silver Lake	Grymes Hill-Clifton-Fox Hills	Stapleton-Rosebank
Population	30381	19211	24198	30762	17902	23846	24985
Uninsured	2905	2966	1148	3380	1756	2379	3805
Percentage	9.6%	15.4%	4.7%	11%	9.8%	10%	15.2%

Average Percentage:
10.7%

Independence care system

Marilyn E. Saviola

Senior Vice President of Advocacy
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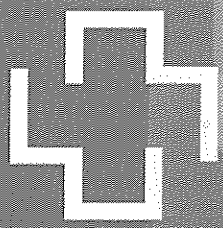

BREAKING DOWN BARRIERS, BREAKING THE SILENCE: MAKING HEALTH CARE ACCESSIBLE FOR WOMEN WITH DISABILITIES

Independence Care System ▪ New York Lawyers for the Public Interest

Report Co-Authors

Independence Care System

Independence Care System is dedicated to supporting adults with physical disabilities and chronic conditions to live at home and participate fully in community life. ICS operates a nonprofit Medicaid managed long-term care plan (MLTC) serving residents of Manhattan, Brooklyn, the Bronx and Queens. Member-centered care coordination is the heart of our work, aimed at ensuring that our members' needs are comprehensively assessed, that they participate in developing their Care Plans, and that they are followed during transitions from a hospitalization or nursing facility back home. Using an interdisciplinary team model of care management, our Care System is responsive, coordinated, expert, empowering, respectful and flexible.

Founded in 2000, ICS was the only plan in New York focused on the unique needs of people with physical disabilities. Since then, our membership has grown to more than 3,000—both people with disabilities and senior adults. We operate a nationally recognized Disability Care Coordination Model and award-winning specialized care management programs in Multiple Sclerosis, Women's Health, and Wheelchair Evaluation and Support.

New York Lawyers for the Public Interest

NYLPI is a nonprofit civil rights law firm whose mission is to advance equality and civil rights, with a focus on health justice, disability justice and environmental justice, through the power of community lawyering and partnerships with the private bar. Created in 1976 to address previously unmet legal needs, NYLPI combines a pro bono clearinghouse with an in-house practice that blends innovative lawyering, community organizing and advocacy.

NYLPI employs a community lawyering approach that revolves around the concept that change is best affected through a dedicated and organized local constituency responding to self-identified problems within their community. In order to address these concerns, NYLPI combines strategies such as advocacy, outreach, organizing, community education, capacity building, policy work, media, and litigation. NYLPI's close working relationship with our almost 100 member firms enables us to leverage the tremendous resources of the private bar in order to have the most impact on the lives of both our clients and New York's nonprofit community.

NYLPI's Disability Justice Program has created a special project, Access to Health Care for People with Disabilities, to break down the barriers that New Yorkers with disabilities face when seeking accessible health care.

Independence care system

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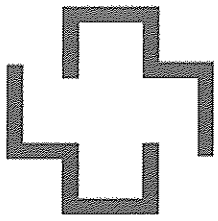

BREAKING DOWN BARRIERS, BREAKING THE SILENCE: MAKING HEALTH CARE ACCESSIBLE FOR WOMEN WITH DISABILITIES

October 2012

"There are too many women with disabilities who have been silenced. We can't be. Some people don't want to tell their stories because it's so painful. When it comes to health care, it's happened so many times, it feels like it's not going to change."

—M. Lyons, Member, Independence Care System

Acknowledgements

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The authors gratefully acknowledge the amazing staff at Independence Care System for their tireless work on behalf of people with disabilities, including Rick Surpin, Regina Estela, Loreen Loonie, Angela Bonavoglia, Susan Wolf, Anna Martinez, Carole Baraldi, Jane Dillera Nietes, and Catherine V. Crowther.

Independence Care System and New York Lawyers for the Public Interest are deeply grateful to the women who courageously spoke out against injustice by sharing their stories in this report. We also recognize all of the participants in Independence Care System's Women's Health Access Program, whose important contributions have helped advance the struggle for accessible health care in New York City.

Table of Contents

"When we talk about concerns with disparities in access to health care, we don't usually hear people with disabilities mentioned. There are a few reasons for this silence.

The Disability Rights Movement has long fought against society's tendency to label people with disabilities as "sick" and dependent on doctors. During the early days of the Independent Living Movement, in an effort to distance itself from this 'medical model' of disability, advocates focused their energies on other areas, such as transportation, education, and employment. In addition, individuals with disabilities have not as easily spoken out or attempted to break down these barriers because they don't realize accessible health care is a right. Many individuals with disabilities are just grateful for any care they can get — they don't want to risk losing it and think that speaking up will get them in trouble. People with disabilities don't always understand this is not the best they can get, and that they deserve more. As a result, hospitals, doctor's' offices and clinics have remained inaccessible to people with disabilities.

Everyone benefits from accessible care and universal design. At some point in your life, you'll probably need something accessible. When you have an adjustable table with varying heights, pregnant women and the elderly don't have to climb up and it's more comfortable for all patients. It's also easier and safer for the practitioner to provide care. Doctors don't have to worry about hurting themselves or the patient.

It is late in the health care game to finally address this crucial issue, but the health of people with disabilities has suffered for far too long. It's time to make health care accessible throughout New York City."

—Marilyn E. Saviola, Vice President of Advocacy and the Women's Health Access Program, Independence Care System

"The law is clear – medical providers of all sizes across New York City are obligated to provide equal care to their patients with disabilities. Yet, our office has heard from many New Yorkers about unequal access, whether because of provider bias, communication barriers, or equipment inaccessibility. This discrimination has prevented people with disabilities from equally availing themselves of critical health services, which we know leads to health disparities. New Yorkers with disabilities cannot be made to endure this injustice any longer.

We will fight alongside the disability community to ensure that medical facilities come into compliance with the law. Healthcare providers in New York City would be well served by taking immediate steps to make their services accessible."

—— Kelly McAnnany, Co-Director, Disability Justice Program,
and Katherine Terenzi, Taconic Policy Fellow
New York Lawyers for the Public Interest

Preface

Independence Care System (ICS) and New York Lawyers for the Public Interest (NYLPI) have long heard complaints from individuals with all types of disabilities about the pervasive inaccessibility of health care in New York City (NYC). These barriers exist in facilities of all sizes, including hospitals, community clinics, and doctors' offices, in contravention of laws that mandate equal access for people with disabilities. ICS and NYLPI have partnered to write this report to illuminate these barriers and to call on medical facilities and state and local government to take immediate action to stop this rampant discrimination. The time for accessible healthcare in New York City for people with disabilities is long overdue.

Inaccessibility is the result of architectural and communication barriers, inaccessible equipment, and provider bias, and the resulting disparities are well documented. Studies have shown that individuals with disabilities are far less likely to access health care services than individuals without disabilities.[1] Women with disabilities, in particular, are significantly less likely to seek or receive quality health care in a timely way, especially in the area of cancer screening.[2] Such significant lack of access to critical services leads to poorer health outcomes for women with disabilities, including higher mortality rates.[3]

The need for accessible care will only increase in the coming years as the baby boom generation ages and life expectancy rates lengthen. Nationally, if the prevalence of major chronic conditions remains the same, the number of individuals with functional limitations will have increased by over 300% by 2049.[4] In New York City, where elderly residents are far more likely to have disabilities,[5] the population over the age of 65 is projected to increase by 44% – or more than an additional 400,000 people – by the year 2030.[6]

Other demographic trends in New York are significant: New Yorkers with disabilities are more likely to be women;[7] over 675,000 adult New Yorkers with disabilities are uninsured or publically insured;[8] and nearly a quarter million adults with disabilities living in New York City earn an annual income that falls below the poverty line,[9] with over half making less than $25,000 in the last year.[10] Despite the obligation of all New York City hospitals to ensure accessibility for their patients, Health and Hospitals Corporation (HHC) facilities have an especially critical role to play in supporting the large number of individuals with disabilities living in poverty[11] who disproportionately rely on the public health system.[12]

With the help of ICS, a few NYC health care facilities, including HHC facilities, have begun to make accessibility improvements for women with disabilities who seek a full range of health services, including breast and cervical cancer screening. These improvements did not generate great expense. Yet, they produced life-changing results for the women who finally benefitted from fully accessible care. These small instances of increased accessibility demand replication, as all New Yorkers with disabilities are entitled to accessible health care.

Medical providers and policymakers have an important role to play in bridging this gap to accessible health care for people with disabilities. This report will provide an overview of the barriers to medical care encountered by New Yorkers with all types of disabilities, as well as outline the legal framework that protects their rights. This report also includes a discussion of the various benefits reaped by medical providers who deliver accessible health care. This report will subsequently probe the specific case of barriers to cancer screening for women with physical disabilities, including the successful steps taken by some New York City providers to be disability inclusive. Finally, this report will make recommendations to medical providers and policymakers on how to fundamentally improve access to health care for New Yorkers with disabilities.

I try to think about it from the perspective of the doctor. I want to believe that they want to give us the best health care, but sometimes the doctor doesn't think about whether the space is accessible, because they're so busy thinking about the services they're supposed to be providing. I wish they'd think about both.

– M. Lyons, Member, Independence Care System

Executive Summary & Recommendations

Executive Summary

Over the years, Independence Care System (ICS) and New York Lawyers for the Public Interest (NYLPI) have heard numerous complaints from individuals with all types of disabilities about the inaccessibility of health care in New York City. Barriers to comprehensive, quality health care appear in facilities of all sizes, including hospitals, community clinics, and doctors' offices. Inaccessibility is the result of architectural and communication barriers, inaccessible equipment, and provider bias. The effect of these obstacles to care is profound; inaccessible health care negatively impacts nearly every aspect of an individual's life, including their social, psychological, physical, and economic well-being. Disparities in access to medical treatment for individuals with disabilities are well documented. Studies have shown that people with disabilities are far less likely to access health care services than individuals without disabilities. Women with disabilities, in particular, are significantly less likely to seek and/or receive quality health care in a timely way, especially in the area of cancer screening. Such significant lack of access to critical services leads to poorer health outcomes for women with disabilities, including higher mortality rates.

Federal, state, and local laws prohibit both public and private health care facilities from discriminating against individuals with disabilities in the provision of medical care. In fact, New York City's local human rights law is one of the most progressive in the country and offers protections beyond the federal laws. Generally, this means that medical providers are responsible for ensuring the accessibility of programs and services by removing architectural and communication barriers, providing reasonable accommodations and accessible medical equipment, training medical and non-medical staff, and making changes to institutional policies and procedures. Compliance with disability anti-discrimination laws benefits patients and providers alike. Not only does the provision of accessible health care ensure a safe environment for patients and employees, but it also reduces the costs associated with patient lawsuits and lost time and expense for worker injuries. Further, medical providers can take advantage of tax incentives for making services and facilities accessible to people with disabilities. Finally, the costs to the health care system are reduced when patients can access care equally, as diseases and illnesses are prevented or diagnosed earlier, and treated for less money, and patients are not forced to rely inappropriately on emergency department treatment.

"My mother and my father both died from cancer, two of my aunts had breast cancer, my brother has cancer, and my sister has breast cancer. Cancer runs in my family so I need to get screened. When I went to one private hospital to get a mammogram the machine didn't lower. During the test my legs started shaking and I felt like I was going to fall and hurt myself. So, I told the woman that I need to sit. She was so rude, she said I could sit when we were done."

– Azzlee Blackwood, Member,
Independence Care System

Barriers to health care disproportionately affect women, and can produce particularly harmful results when they impede effective screening for cancer; disparate treatment can delay or inhibit the early detection of breast or cervical cancers. Although women with disabilities have the same incidence rates of breast cancer as women without disabilities, they are one-third more likely to die from it. Women without disabilities also receive mammograms eleven percent more frequently than women with physical disabilities. Studies have shown that among women with disabilities aged forty and over who had not had a mammogram within the past two years, the most frequently cited reason was the inability to get into the required position.

Although the majority of medical facilities have a long way to go to come into compliance with disability laws, efforts to achieve accessible care are

already underway in New York City hospitals. ICS, which operates a nonprofit Medicaid managed long-term care plan specifically designed for adults with physical disabilities and chronic illnesses, has spent several years developing its Women's Health Access Program. This program seeks to increase the accessibility of breast and gynecological care and other health services for women with physical disabilities. ICS, along with partner medical facilities, has made significant progress in developing and implementing a model of accessible cancer screening for ICS members. The key to this program's success has been a willingness by providers to take necessary steps to change policies and procedures, remove physical barriers, and educate staff to ensure disability competency. The success of these collaborations must be replicated across other healthcare facilities in New York City.

"Women's health care is important, and it is even more important for women who use wheelchairs. People don't realize that when you take away the wheel chair, I'm just a woman looking for health care."

– C. Cruz, Member,
Independence Care System

The time for accessible health care has come. New York City medical providers must immediately take steps to remedy the pervasive inequality that leads to substandard health care for New Yorkers with disabilities.

Recommendations to Medical Providers & Policymakers

Medical providers and policymakers have important roles to play in bridging the gap to accessible health care for women with disabilities. The following recommendations, if implemented, will make long overdue changes to our health care system and help guarantee equal access to health care for people with disabilities in New York City.

New York City Medical Providers should:

- Develop and implement a comprehensive plan for treating people with disabilities, including by instituting a non-discrimination policy with accompanying protocols, designating a point person and creating a grievance procedure to ensure patients with disabilities receive disability accommodations
- Develop and conduct mandatory system-wide disability competency provider trainings
- Acquire accessible equipment and remove communication and architectural barriers
- Coordinate care and maintain good data and records on patients with disabilities

The New York City Health & Hospitals Corporation should, in addition to the aforementioned recommendations:

- Convene a task force, including representatives from each facility, experts, stakeholders, and people with disabilities, to develop detailed guidance on ensuring accessibility in health care facilities in compliance with existing law
- Develop and disseminate a patient and provider survey regarding the accessibility of HHC facilities and services

The New York City Council should:

- Pass a comprehensive resolution, which directs New York City medical providers to comply with disability anti-discrimination laws; directs HHC to convene a task force to develop guidance on accessibility; urges the New York State Department of Health to issue and enforce detailed guidance to health care facilities on the provision of accessible care, to create an accessible complaint process, and to amend facility requirements to include disability training and intake; and urges the New York State legislature to pass legislation requiring medical facilities to procure accessible medical equipment and to issue patient notices regarding their right to accessible care
- Include funding in the budget, with terms and conditions, to assist capital improvements at HHC facilities that are designed to increase accessibility for people with disabilities
- Convene annual oversight hearings on the accessibility of medical services and the needs of people with disabilities

The New York State Department of Health should:

- Issue a detailed administrative directive to all medical facilities regarding the obligation to provide accessible services to people with disabilities, and ensure facility compliance with said directive and disability anti-discrimination laws
- Create a robust and accessible complaint process with defined follow-up procedures
- Amend facility requirements on training and intake to include disability

The New York State Legislature should:

- Pass legislation requiring all medical facilities to provide notice to patients of their rights to accessible care
- Pass legislation requiring all medical equipment procured by hospitals and clinics to be accessible in compliance with anti-discrimination laws and regulations

"Our sexual health is extremely important. We are the ones bringing life into this world. Yes, disabled women are also bringing life into this world. It is extremely important."

– Kim Yancy, Member, Independence Care System

Common Barriers to Accessing Healthcare Services

> **"A physician shall support access to medical care for all people."**
>
> — Principle IX, American Medical Association's Code of Medical Ethics[13]

> **"One public hospital mammography supervisor even told me, 'People like you cannot come here.' When I asked where I should go, the supervisor responded 'where people like you go.'"**
>
> — Marilyn E. Saviola, Vice President of Advocacy and the Women's Health Access Program, Independence Care System

New Yorkers with all types of disabilities face barriers to accessing basic health services, whether at hospital-based facilities, community clinics, or doctors' offices. Obstacles include structural barriers, inaccessible equipment, communication barriers, and provider bias. The effect of these obstacles is profound; inaccessible health care negatively impacts nearly every aspect of an individual's life, including their social, psychological, physical, and economic well-being.[14]

Over the years, Independence Care System and New York Lawyers for the Public Interest have heard numerous complaints from individuals with disabilities about the inaccessibility of health care in New York City.[15] The following section provides an overview of such barriers.

Physical Barriers

Physical barriers can impede access to medical care in nearly every part of a doctor's office or hospital, from the building entrance to the examination room.[16] These physical barriers can be structural or architectural in nature, as well as result from the use of inaccessible medical equipment.

Examples of structural obstacles include restrooms without grab bars, intake areas with insufficient turning space for a wheelchair, and hallways that are too narrow.[17] Many doctors' offices in New York City also have one or more steps to the entrance, and are often located in buildings without an elevator.[18] Individuals who use mobility aids, such as a wheelchair or walker, may also face barriers to obtaining comprehensive examinations and testing as a result of inaccessible equipment. They may be unable to get onto an examination table that is too high, or use diagnostic equipment that will not lower.[19] Doctors may then perform an incomplete procedure, including by examining a patient while she remains in her wheelchair, despite the inadequacy of such a method.[20] Individuals with physical disabilities may lack the strength or balance to stand to be weighed, but providers often use weight scales that are not wide or flat enough to allow for a wheelchair or other mobility device.[21] As a result, medical staff may altogether forego weighing the patient.[22]

Studies throughout the country reveal the routine absence of accessible examination tables, weight scales and diagnostic equipment. In a national survey of people with disabilities or activity limitations, 69% of wheelchair users reported that they had difficulty using exam tables, 60% had difficulty being weighed due to inaccessible scales, 45% had difficulty using x-ray equipment (such as mammography equipment), and 43% had difficulty using medical chairs.[23] Only 1% of the providers surveyed in another study had an accessible scale.[24]

The result of medical provider failures to ensure structural accessibility or utilize accessible equipment can range from humiliation to the development of life-threatening conditions that could have been prevented.[25] Lack of access to appropriate health services increases the risk that people with significant disabilities will develop additional health conditions. People with disabilities also generally experience higher rates of secondary conditions than the general population, which compounds barriers.[26]

Communication Barriers

Physical barriers are not the only obstacles that people with disabilities confront when seeking medical care; communication barriers routinely prevent individuals with disabilities from fully understanding or relating their medical condition and treatment needs.

Deaf and hard of hearing New Yorkers regularly fail to receive a qualified sign language interpreter at doctor appointments and during trips to hospital emergency rooms. In addition, deaf or hard of hearing individuals are routinely not provided with communication devices that replace telephones, called videophones, during longer-term stays at hospitals or rehabilitation facilities.[27] The health disparities that result from this kind of unequal care are numerous. Research has shown them to include, "medication errors and missed diagnoses, problems during surgery and anesthesia, missed and delayed appointments, and less complete and accurate information than other patients receive."[28] Basic information about health conditions is also not communicated to the deaf community. In a large survey of patients who are deaf, 62% of patients surveyed could not identify the warning signs of a stroke, 32% could not identify the risk factors of heart attack or stroke, and one in three could not define the word "cancer."[29] Another startling study showed that 70% of deaf individuals said that people who are deaf could not get HIV and 50% did not know the meaning of HIV-positive.[30]

Communication barriers similarly affect the growing population of New Yorkers who are blind or have low vision.[31] People with visual impairments are routinely not provided with important medical information and documents in a format they can read, such as Braille or large print.[32] For example, in a study of Medicare beneficiaries with severe vision impairments, rates of dissatisfaction with the quality of health care received and inadequate information provided about their health conditions were nearly double the rates seen in the general population.[33] During hospital stays, medical personnel may also fail to give blind individuals information about their surroundings, which would otherwise facilitate independence and greater comfort.[34] Doctors may also tell patients they are not allowed to bring their service animal into an appointment.[35]

"I've had the experience where they talk to the aide instead of talking to me to ask what I need and how to transfer. I'm kind of feisty, so I say 'I can answer for myself.' But it dehumanizes me. They don't even attempt to ask, 'what can you do?' or 'why are you here?' Sometimes you feel like it's the elephant in the room."

– M. Lyons, Member,
Independence Care System

Barriers for individuals with developmental disabilities and mental illness also implicate a lack of appropriate and effective communication on the part of medical staff. Doctors and nurses may fail to take the necessary time to explain a procedure or treatment options to a person with a mental illness or an intellectual disability.[36] Medical staff may also fail to ask what steps are necessary to ensure a comfortable and safe environment for an examination, including by offering to provide additional staff to support the individual.[37] Data relating to the health outcomes of people with mental illness are particularly disturbing. For example, individuals with mental illness receive inferior preventive care services, such as osteoporosis screening, blood pressure and cholesterol monitoring, vaccinations, and mammography.[38] In high-income countries, there is a 20-year and 15-year life expectancy gap, respectively, for men and women with mental illness.[39]

Attitudinal Barriers & Lack of Training

The lack of cultural competency leads to a number of incorrect and detrimental assumptions about people with disabilities made by healthcare providers. Discriminatory perceptions have led providers to believe, for example, "that people with disabilities do not have a good quality of life; that people with developmental disabilities do not feel pain and, therefore do not require anesthesia; that people who are deaf have cognitive deficits because they may not be fluent in standard English; and that women with disabilities do not require reproductive counseling and care because they are not sexually active."[41] Research shows that these stereotypes and biases negatively affect the quality of care patients with disabilities receive.[42]

Research reveals that physicians have not received training on the fundamental aspects of working with people with disabilities. In a 2007 survey of primary care physicians, 91% of them revealed that they had never received training on how to serve people with intellectual or developmental disabilities.[43] According to a national study of physicians, only 2.6% of respondents demonstrated specific awareness of the ADA.[44] Another survey of more than 500 physicians revealed that nearly 20% of respondents were unaware of the ADA and more than 45% did not know about its architectural requirements.[45] Moreover, less than a quarter of the respondents had received any training on physical disability issues in medical school, and only slightly more than a third had received any kind of training on disability during their residency.[46] However, nearly three quarters of the physicians surveyed acknowledged a need for training on these issues.[47]

The following section will provide an overview of the multiple laws that shield patients with disabilities from the aforementioned discrimination that exists in medical facilities in New York City.

"The patient has the right to confidentiality. The physician should not reveal confidential communications or information without the consent of the patient, unless provided for by law…"

– American Medical Association Opinion 10.01(4), "Fundamental Elements of the Patient-Physician Relationship"[40]

"Another young lady with a disability was [at the gynecologist's office] when I was there and the doctor raced around the place saying, "Oh my god, she's pregnant; I can't believe it, she can't be!" She was so loud everyone in the waiting room heard it. I was disgusted. When I went in for my appointment they did a pregnancy test on me even though I didn't request it. When it came back negative, they said "Oh, well thank god you're not pregnant!" I cannot even begin to tell you how upset I was, not only for myself, but for the other woman– she was a grown woman with a job – and they carried on so horribly."

– Kim Yancy, Member, Independence Care System

Legal Framework for Providing Accessible Care

"A physician shall respect the law..."

—Principle III, American Medical Association's Code of Medical Ethics[48]

"When you have a physical disability and you're looking for a gynecologist, you usually have to settle. Most women don't know that the facility should be accessible, so we tend to adapt. We don't know any better, so we settle. For example, I went to one place and the only thing that was accessible was the front door."

– C. Cruz, Member, Independence Care System

Health care providers in New York City have long been legally required to make their services fully and equally accessible to people with disabilities. In addition to prohibiting the outright exclusion or segregation of people with disabilities, laws require public and private medical providers of any size to remove physical barriers, provide accessible medical equipment and communication aids, and make changes to policies and procedures. This section will provide an overview of the specific requirements of relevant federal, state and local laws that pertain to health care providers in New York City.

Anti-Discrimination Laws that Protect New Yorkers with Disabilities

Four key laws collectively prohibit discrimination against people with disabilities in virtually all healthcare facilities in New York City: Section 504 of the Rehabilitation Act of 1973 (Rehab Act), Titles II and III of the Americans with Disabilities Act of 1990 (ADA), the New York State Human Rights Law (State Human Rights Law), and the New York City Human Rights Law (City Human Rights Law).

The Rehab Act applies to programs and institutions that receive federal financial assistance, meaning that all medical care providers that receive payments from Medicaid or Medicare (excluding Part B payments) are covered by Section 504.[49] Title II of the ADA covers state and local governments, referred to as "public entities," and includes "health services," such as state and city hospitals and clinics, without regard to federal funding.[50] Title III of the ADA covers all "places of public accommodation," which are generally places that are open to the public where an individual can go for goods and services.[51] Thus, it covers private doctors' offices, hospitals, and clinics.

The State Human Rights Law generally tracks the protections guaranteed to people with disabilities by the federal anti-discrimination laws described above, in particular the ADA.[52] In New York City, the City Human Rights Law surpasses the protections of federal and state law, as confirmed by the Restoration Act of 2005.[53] The State and City Human Rights Laws both apply to private doctors' offices, hospitals, and clinics as places of public accommodation.[54]

Although the definition of disability under each of the aforementioned laws differs slightly, generally a person with a physical, medical or mental impairment is considered a person with a disability.[55] These laws also protect individuals from discrimination even if they are only "regarded as" having or have a "record" of a disability.[56] Finally, these laws prohibit providers from retaliating against an individual for opposing an unlawful act or practice, such as demanding a reasonable accommodation.[57]

Steps to Providing Accessible Care

While each law has unique features and requirements, generally all of the laws outlined above mandate health care accessibility for New Yorkers with disabilities in similar ways. First and foremost, such laws prohibit medical providers from the outright exclusion of – or the provision of separate and unequal benefits to – people with disabilities.[58] In addition, medical providers must take action to ensure full and equal access to medical care for people with disabilities in the following three general ways: (1) by removing physical barriers; (2) by providing "auxiliary aids and services"; and (3) by making reasonable changes to policies and procedures.

First, both public and private medical providers must remove physical barriers that limit access to medical care for people with disabilities unless such a requirement would fundamentally change the nature of the program or would result in an undue financial or administrative burden.[59] For example, medical providers are required to remove architectural barriers such as steps, narrow doorways or inaccessible toilets.[60] Providers are also responsible for providing accessible medical equipment, such as exam tables that raise and lower, accessible weight scales, and accessible mammography machines.[61] Medical providers are required to alter exam rooms and waiting rooms as necessary to ensure people with mobility impairments have access to these areas.[62] Medical facilities also bear the responsibility of transferring patients to equipment when they are otherwise unable to do so independently; they must not rely on the patient's family member, friend or aide to assist.[63] Providers must train staff – immediately and on an ongoing basis – on the proper transfer techniques, as necessary.[64] Beyond transfer training, providers must train staff to identify and locate "which examination and procedure rooms are accessible and where portable accessible equipment is stored."[65]

Second, in addition to removing barriers, health providers are required to offer "auxiliary aids and services," to individuals who are deaf, blind or have low vision.[66] Auxiliary aids and services can be broadly described as aids or services that help to ensure effective communication is taking place.[67] Such aids and services include qualified sign language interpreters (on-site or through video remote interpreting), the exchange of written notes, assistive listening devices, and information provided in large print or Braille.[68] Medical providers must produce such aids and services unless it would create an undue administrative or financial burden or would fundamentally change the nature of the program or service being provided.[69] Although the language differs slightly, both Title II and III of the ADA obligate medical providers to ensure that they maintain "effective communication" with individuals with disabilities, which may include the provision of auxiliary aids and services.[70] The responsibility to provide the auxiliary aids and services rests with the medical provider, and a hospital or doctor's office "shall not require an individual with a disability to bring another individual to interpret for him or her."[71] In addition, when a medical facility provides an accommodation, such as a sign language interpreter, it cannot ask the individual with the disability to bear the cost.[72]

Third, medical providers must make reasonable modifications to policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability and would not result in an undue financial or administrative burden or fundamentally change the nature of the service or program.[73] For example, a clinic that does not normally allow animals within the facility may need to provide an exception to this policy in order to allow patients to attend appointments with their service animals.[74] Additionally, hospitals, clinics and private practitioners are required to train their medical and non-medical staff on disability competence in order to ensure that patients with disabilities are offered necessary accommodations.[75] For example, staff must take extra time to explain a procedure or course of treatment to a person with an intellectual disability, or to help position a patient with cerebral palsy who experiences spasticity or tremors during a physical examination.[76]

"The provisions of this title shall be construed liberally for the accomplishment of the uniquely broad and remedial purposes thereof, regardless of whether federal or New York State civil and human rights laws, including those laws with provisions comparably-worded to provisions of this title, have been so construed."

– Admin. Code of the City of New York § 8-130

The Costs of Inaccessible Health Care

Compliance with the aforementioned disability anti-discrimination laws benefits medical providers and patients alike. Not only does the provision of accessible health care greatly reduce the likelihood of successful lawsuits against providers for civil rights violations, but it also ensures a safe environment for patients and employees and reduces injury-related costs. Further, medical providers can take advantage of tax incentives for making services and facilities accessible to people with disabilities. Finally, the costs to the healthcare system are reduced when patients have equal access to care.

Increased Liability Exposure

Medical providers who comply with federal, state, and local disability laws can greatly reduce their risk of liability. Conversely, facility and program inaccessibility can subject health care providers to costly litigation, including lawsuits grounded in civil rights and/or torts claims.

Health care accessibility violations, as outlined above in the Common Barriers section, are generally actionable through lawsuits in court and administrative complaints with enforcement agencies.[78] For example, medical providers who have wrongly refused to provide accessible medical equipment, or transfer patients with disabilities who cannot independently use medical equipment, have been found to be in violation of the law.[79] Similarly, doctors who refuse to provide a sign language interpreter to a deaf patient may violate the law for failing to establish effective communication with such patient.[80] Providers who refuse to allow patients with disabilities to bring their service animals into their office also violate the law.[81]

These failures to provide accessible services can also lead to inadequate care, misdiagnosis, improper treatment, and/or injury to the patient. Patients may recover compensatory damages for the physical harm they suffer as a result of these violations.[82] Even in the absence of physical harm, patients with disabilities who are subjected to inaccessible care in violation of civil rights laws can recover compensatory damages for emotional or financial harm.[83] Injunctive relief, such as mandating that the provider make changes to policies and procedures or provide reasonable accommodations at facilities, is another common remedy secured through lawsuits and administrative complaints.[84] Plaintiffs who prevail in lawsuits may be entitled to attorney's fees and costs under relevant federal, state and city laws.[85] Finally, in some cases, judges may impose civil penalties to vindicate the public interest.[86]

"Patients with special needs – and their advocates – are gaining traction in obtaining accommodations to reduce their risks of substandard care... [s]ubstandard preparation puts patients at risk of harm and providers at risk of potentially indefensible allegations of negligence. Practitioners and facilities primed and equipped for special needs patients are more likely to avoid the most egregious and damaging errors (and lawsuits)."

– Pamphlet on Patient Safety, Academic Group, A Medical Malpractice Insurance Provider[77]

Increased Incidence of Patient & Worker Injury

Beyond limiting exposure to liability, facilities can protect the health of patients and workers, as well as reduce costs, by providing a combination of universally accessible equipment, lift and transfer equipment, and staff training on safe transfer techniques for patients with mobility impairments.

First, patient safety is enhanced by a combination of accessible equipment, proper lifting/transferring techniques, and mechanical lifts and repositioning devices. As discussed in the Legal Framework Section, medical providers should use universally accessible equipment whenever possible, but when equipment cannot be used independently by a person with a disability, it is the responsibility of the medical provider to provide assistance. When such assistance involves transfers, providers can ensure patient safety by implementing safe patient handling techniques, which incorporate lift and transfer equipment and training, as opposed to solely manual lifting techniques that are proven to be unsafe.[87] Manual lifting methods hurt patients, who "both physically and mentally feel the impact of a lift."[88] As detailed in a report on safe patient handling, transfer technology that assists nurses and technicians can help prevent major injuries to patients, such as falls.[89] Safe patient handling also "lessens patient anxiety and enhances patient dignity and autonomy" while simultaneously reducing "the potential for patient injury (e.g., skin tears, joint dislocations, falls)."[90]

"[T]raining staff to properly assist with transfers and lifts, and to use positioning aids correctly will minimize the chance of injury for both patients and staff."

–Department of Justice Guidance, Access To Medical Care For Individuals With Mobility Disabilities

In addition to protecting patient safety, health care facilities that provide accessible services not only protect their workers, but also expend less time and money. To begin with, the use of universally accessible equipment, such as adjustable exam tables, can "reduce the frequency and time required in using a lift team, lift equipment and/or providing transfer assistance from staff."[91] When such equipment is not available – and medical staff must assist with patient transfers – providers can reduce worker injuries by using the aforementioned safe patient handling methods and patient lift technology.[92] Finally, studies of medical providers who have invested in safe patient handling programs reveal significant cost savings due to a reduction in employee injuries, worker's compensation costs, medical/indemnity costs, and lost work days or absenteeism.[93]

Small facilities and for-profit health care entities, such as private doctor's offices, may not experience the same level of savings as hospitals that serve a large in-patient population that requires transfers on a regular basis. However, such entities are still responsible for making their services accessible to patients with limited mobility. These entities can take advantage of tax incentives for accessibility improvements to buildings and services under the "Disabled Access Credit." This credit allows small businesses – defined as those with thirty or fewer employees or total revenue of $1 million or less[94] – to apply for a tax credit of up to $5,000 or half of eligible expenses per year.[95] Eligible expenses include barrier removal, whether facility or communication based, and provision or modification of equipment.[96] Businesses of any size can also utilize a tax deduction of up to $15,000 per year for removing barriers in facilities.[97]

Increased Costs to the Healthcare System

The costs of inadequate care extend beyond calculations of healthcare facility savings and limited liability exposure; our healthcare system incurs significant costs due to unequal access for people with disabilities. When patients with disabilities receive inadequate health care, it may mean that a diagnosis is missed and the disease progresses, which can cost more to treat. For example, late diagnosis of breast cancer, which occurs at a higher rate for women with disabilities due to barriers to mammography,[98] is more costly to treat and takes more lives than when it is caught early.[99] Inaccessibility and barriers to care may also lead people with disabilities to more frequently utilize emergency departments for preventive services than the general population,[100] all at a greater cost.[101] A national survey calculated that receipt of non-urgent care in an emergency department was seven times more expensive than receipt of the same services in a health center.[102] Providing quality accessible care to people with disabilities in all health care settings would eliminate these high costs to the healthcare system.

Case Study: Accessible Cancer Screening Services for Women with Disabilities

Barriers to health care disproportionately affect women with disabilities. While they appear everywhere, including routine exams and procedures, when such barriers prevent proper screening for cancer, the consequences can be deadly.[103] We must eliminate this insidious inequality to protect the nearly half a million women with disabilities living in New York City who should be receiving regular gynecological care, the vast majority of whom should also be receiving annual mammograms.[104]

Health disparities for women with disabilities are startling, and they can lead to delayed or missed diagnoses of breast or cervical cancers. For example, women with disabilities have the same incidence of breast cancer as women without disabilities, yet they are nearly one-third more likely to die from it.[105] When data from a national survey was analyzed for a subsection of the disability community comprising women with major mobility impairments, researchers found that these women were nearly 20% less likely to have received a mammogram in the last two years.[106] Disparities for women with mental disabilities are even starker; after adjusting for comorbid conditions, women with mental illness were more than 30% less likely to receive a mammogram[107] and only 12% of women with intellectual disabilities received timely mammograms.[108] Mortality rates for women with disabilities due to breast and cervical cancer could be significantly reduced if timely screening and treatment was made accessible for all women.[109]

"A solid body of evidence confirms disparities in care – especially cancer screening services – for women with disabilities. For example, our studies using nationally representative databases find that women with physical disabilities are significantly less likely to receive Pap tests to screen for cervical cancer; disparities in mammography screening also exist, although patterns of these differences vary by disability type. These large national surveys typically do not reveal why disparities exist, but our studies using focus groups and in-depth individual interviews provide clues. Clinicians may erroneously think that women with disabilities are sexually inactive and therefore not at risk of exposure to the human papillomavirus linked to cervical cancer. Women with physical disabilities tell me that their clinicians often do not have accessible examining tables and examine the women while they sit in their wheelchairs – hence, no Pap test! Our research finds that these disparities in care can increase mortality and morbidity and also worsen quality of life of women with disabilities."

– Lisa I. Iezzoni, MD, MSc, Director of the Mongan Institute for Health Policy at Massachusetts General Hospital & Professor of Medicine at Harvard Medical School

This section will identify the multiple obstacles women with physical disabilities face in accessing breast cancer screening and gynecological care, and reveal how those barriers have been dismantled at a handful of private and public health facilities in New York City. While these changes have focused solely on the barriers encountered by women with physical disabilities, similar changes must be made to eliminate barriers encountered by women who, for example, are deaf or hard of hearing, or have mental disabilities. Medical providers must eliminate obstacles and ensure that women with disabilities receive quality, accessible care in accordance with civil rights laws.

Improving Cancer Screening Accessibility in New York City

The vast majority of medical facilities in New York City have work to do to come into compliance with disability anti-discrimination laws. However, incremental improvement in accessibility is already underway thanks to the efforts of one New York City advocacy organization. These efforts must not remain limited to this tiny sliver of the healthcare community – all medical providers must ensure that patients receive the accessible care to which they are entitled.

"No one wants to get a mammogram. But if you're going to be treated like you're a problem because of your disability, it's even more of a hassle and no one is going to want to go."

– Marilyn E. Saviola, Vice President of Advocacy and the Women's Health Access Program, Independence Care System

Independence Care System (ICS) operates a nonprofit Medicaid managed long-term care plan specifically designed for adults with physical disabilities and chronic illnesses. The majority of ICS's members are women, and they are all recipients of Medicaid. In response to concerns expressed by its members about their negative experiences seeking health care over the years – they had no fully accessible location at which they could receive breast and gynecological care – ICS decided to take action. With funding from the Greater New York City Affiliate of Susan G. Komen for the Cure® since 2008, ICS has been developing and implementing its Breast Cancer Screening Project for Women with Physical Disabilities.[110] Recently, with a grant from the Baisley Powell Elebash Fund, ICS expanded its Women's Health Access Program to include gynecological care.

In the first year, ICS identified two provider sites with which to partner: New York Presbyterian Hospital-Columbia University Medical Center, a provider site of the Columbia University Breast Cancer Screening Partnership Program, and the Breast Examination Center of Harlem, a program of Memorial Sloan Kettering Cancer Center. Beginning in the fourth year of the project, ICS expanded its advocacy to include gynecological care, as well as breast cancer screening, at two additional facilities: the Morrisania Diagnostic and Treatment Center in the Bronx, a clinic affiliated with Lincoln Medical Center, and Woodhull Medical Center in Brooklyn, at which ICS plans to fully operationalize a program in the coming year. The two most recent partnerships are particularly significant given that they are with Health and Hospitals Corporation facilities (i.e. public hospitals), where most ICS members, as well as underserved New Yorkers, receive their care. Through its two projects, ICS has helped secure more than 200 accessible breast and gynecological cancer screenings for its female members with disabilities.

ICS's projects reveal how a commitment to accessibility from health care institutions can lead to the successful elimination of barriers encountered by women with disabilities. In conducting these projects, ICS identified three major areas in which providers had to make changes to ensure accessibility. The first step was for facilities to identify and eliminate physical barriers to care. The second step was for partner facilities to conduct, with ICS's assistance, disability awareness and sensitivity training for doctors, nurses and staff. Finally, partner facilities altered the coordination and intake process for patients with disabilities to reduce inefficiencies and increase comfort. Each of these steps was critical to ensuring that women with mobility impairments had a positive experience and received comprehensive cancer screening. The fundamental tenets of these projects demand replication by other New York City healthcare facilities.

Remedying Physical Barriers & Inaccessible Equipment

Through both its breast and gynecological screening projects, ICS found a wide array of physical and/or structural barriers in partner locations. Notably, solutions were often readily available and did not incur great cost. As part of the projects, ICS met with clinical and executive staff at each facility to discuss the most prevalent barriers, including those identified by ICS members through surveys, and together made a plan to improve the facility's physical space, procedures and practices to ensure accessibility.

Mammography Project

Equipment barriers were commonplace at the breast cancer screening project partner facilities. For example, mammography machines were often inaccessible for ICS members with mobility impairments who could not stand or hold their arms high enough. Other ICS members experienced uncontrollable movements and could not keep their arms steady in the required position, which made it difficult to successfully complete a mammogram. Although the ideal solution would be universally designed mammography equipment,[111] simple interim solutions helped address these barriers; positioning aides, such as Velcro straps, were used to support the women's arms during the test and additional technologists assisted as necessary to help with positioning.[112] ICS's Nurse Educator accompanied the project participants to their appointments and shared helpful techniques with the technologist regarding positioning and wheelchair placement. She also instructed the technologist on what other assistance was necessary to allow for an accurate and comfortable mammogram, such as using a lumbar pillow for back support. Women who visit the partner facilities are now able to stay in their wheelchair or, in the case of one partner facility, to transfer to an adjustable mammography chair, depending on what is most comfortable and can provide the best screening image.

Design and structural barriers also contributed to concerns about ICS members' ability to fully access care. In one facility the design of the mammography suite presented a major problem; the room had a console in the middle of the floor that obstructed the path to the mammography machine for women in power wheelchairs and scooters. In response, the facility reconfigured the area, moving the console to the edge of the room. This fix allowed for additional space and ensured that women in wheelchairs were no longer denied access to mammograms.

Gynecological Project

"I have cerebral palsy. [At other places,] sometimes they used a q-tip to examine me because of my spasticity. I was worried about the actual reading, and whether they could really check for cancer cells because they just swabbed the surface, and didn't swab my cervix. I don't know if it was because I couldn't relax enough – I felt like I was going to fall off the table."

– M. Lyons, Member,
Independence Care System

Physical barriers were similarly present in partner gynecological care facilities. Equipment, such as examination tables and weight scales, initially were not fully accessible to ICS members who participated in the project. This discovery was consistent with experiences the women had previously had at other facilities. The majority of ICS members who participated in the project had never had an accessible table available to them; the primary reason cited for not having previously received a gynecological exam was that the examination table was too narrow, high, and/or flat.[113] ICS members reported previously having not received full examinations or procedures.[114]

In response to these barriers, Morrisania obtained an accessible weight scale and Hoyer lift for its exam room, as well as purchased and installed accessible features for its height adjustable exam table. Such features comprised adjustable stirrups, leg supports, a movable headrest, and side rails. The modified tables, in particular, completely changed the experience for the ICS members. One ICS member explained that after years of visiting the doctor, her visit to Morrisania was her first fully accessible gynecological experience.[115]

Educating Staff to Address Provider Misconceptions & Ignorance

Provider bias and inadequate counseling prevents women with disabilities from seeking and receiving comprehensive cancer screening.[116] Both ICS projects revealed gaps in knowledge and counseling for members that required sensitivity and cultural competency training to address.

In addition to misconceptions about mammograms, facility inaccessibility and the failure of providers to properly counsel women with disabilities contributed to ICS members' reluctance to get screened. ICS members were often completely unaware that they needed to get a mammogram because their provider had previously failed to recommend it to them or told them they could not receive one since they were in a wheelchair.[117] ICS members were also unable to find an accessible and welcoming location where they could receive the screening.[118] ICS reported that their members were reluctant to get mammograms because they "believe that having one significant medical condition precludes their having another; fear that because of their disabilities they will be unable to endure the exam; or feel overburdened by multiple medical appointments."[119] The inconvenience of mammograms is compounded by the disability-related barriers that women face every day, such as a lack of transportation or the need to coordinate home care services. These additional barriers make it even more critical that providers emphasize the importance of breast cancer screening to women with disabilities. To address this gap in knowledge, ICS organized workshops and instituted a one-to-one outreach program where staff called hundreds of women to educate them on the importance of mammograms and early detection.[120] Once the women heard about ICS's breast cancer screening project, many were relieved that they could actually receive the testing they needed in a facility that was accessible to them.[121]

"[When I went to the gynecologist through the ICS program] it was the first time anyone had ever asked me, 'Would you like to have a child?' I am 37 years old and no one has ever asked me anything like that."

—Kim Yancy, Member, Independence Care System

ICS members had also received inadequate gynecological care because of provider bias. For example, several ICS members reported not being asked by their gynecologist whether they were sexually active.[122] Woman who participated in the gynecological project also reported that their previous physician was insensitive to their needs. The majority of ICS members surveyed who received a pelvic exam and Pap smear before joining the project reported that they did not go back because it was too traumatic.[123] ICS members experienced trauma from the extreme difficulty encountered in trying to get on the exam table, not being able to fit their legs into non-adjustable stirrups, and being made to feel as though they were the problem.[124] One woman reported that her previous gynecologist had threatened to leave if she did not stop the uncontrollable leg spasms she experienced due to her disability.[125] The majority of members reported that their gynecologist had never explained the reason for the test, how it would be performed, or when they could get the results.[126]

To address the barriers identified in both the breast and gynecological care projects, ICS implemented a Disability Awareness and Sensitivity Training program for all partner facility staff, including clerical, support, clinical and administrative workers. The training included elements of cultural competency and technical skills for working with women with disabilities. In particular, the training emphasized the creation of a patient-centered environment through sensitivity to the woman's needs and a consciousness of how provider misconceptions may interfere. For example, in the context of gynecological care, doctors and other staff were instructed not to assume a woman with a disability does not want to have children, to listen to the woman's suggestions for the best positioning, and to thoroughly explain all procedures before performing them. The gynecologist at Morrisania incorporated this knowledge into her practice and ICS members note that when this gynecologist sees them, they feel they are finally being respected fully as women, as human beings, in a way that many providers have previously failed to do.[127] This kind of training must be replicated in other healthcare facilities to ensure that providers are providing culturally competent care to their patients with disabilities.

"My first time in the ICS program, everything was in one room so I didn't have to undress and come in through the back door. I usually have a real hard time with spasticity, but the chair lift worked and I was able to get on the chair pretty much by myself. That the table actually came down to me – that made a huge difference. She did the examination the way it should be done. I'm 49 years old and that was the first time I had a totally accessible experience."

– M. Lyons, Member, Independence Care System

Creating Procedures to Increase Efficiency & Accessibility

The final area addressed at partner facilities through the ICS projects was altering how the facilities scheduled appointments and conducted patient intake. Prior to these adjustments, ICS members had encountered numerous problems with insufficient reasonable accommodations and inefficiency when seeking health care at facilities.

ICS encouraged each partner facility to add a functional assessment section to the intake forms with a series of simple questions, such as whether the woman could transfer or raise her arms, to evaluate what accommodations may be necessary.[128] This form was filled out and sent to the facility in advance of the appointment to allow the facility staff to plan accordingly for the appointment. For example, the staff could ensure that an extra technologist was available, or additional time was scheduled, as necessary. The form remained in the patient's chart so the facility and physician could reference it in the future, as opposed to repeatedly asking the patient to rehash her needs every time she visited. Making procedural accommodations of this sort also prevented women with disabilities from experiencing extensive delays which could cause them to miss their transportation, and take them hours to reschedule.[129] These accommodations also meant that ICS members did not have to worry that their home care worker would go off duty and be unable to accompany them home, or that they would be forced to pay for the additional time.

Another simple, yet helpful, procedural change implemented through the ICS program was to ensure that patients could receive as many elements of care as possible in the same location. For example, when relevant, the facilities took the patient's vitals and weight in the same room in which they were being seen for the mammogram or gynecological screening. Of particular importance, the facilities made changes so that women who used mobility aides were able to change into the patient gown in the mammography suite for breast exams, or the exam room for gynecological visits. This adjustment allowed for smoother transitions and afforded ICS members more privacy; previously the women had to change in one location and move to another using their mobility aid, while trying with great difficulty to keep themselves covered. With this very minor adjustment, women with disabilities experienced a much more comfortable and private visit. For mammograms, this procedural adjustment also reduced the time needed for an exam.[130]

The vast majority of barriers that ICS members identified were successfully addressed by partner providers; however, some providers expressed an unwillingness to implement recommended changes out of misplaced concerns about liability. For example, one provider was reluctant to use positioning aids, specifically Velcro straps, for fear that institutional policies on restraints prohibited the use of such devices.[131] These liability concerns were unsubstantiated. Laws and regulations prohibiting the improper use of restraints, which were passed in response to patient abuse and neglect in mostly in-patient settings, do not apply to positioning aids used for routine medical screenings and diagnostic tests in outpatient settings.[132] In fact, most statutory and regulatory definitions of restraint explicitly exclude the use of assistive devices.[133]

Clearly, not only do medical providers need to commit to making their services accessible, but they could also benefit from additional guidance and oversight from various entities to ensure that their practices comply with the law.

"Where can other women with disabilities [who are not ICS members] go to get these mammograms and pap smears done and be comfortable? There's a lot of people out there who don't get a mammogram or a pap smear..."

– Esther J., Member, Independence Care System

Next Steps for Accessibility Across New York City

Five and a half months into its Breast Cancer Screening Project, ICS was still struggling to find a medical provider that was willing to partner with them. Facilities displayed "reluctance, resistance, discrimination, and outright hostility" when ICS approached them about collaborating to provide accessible services.[131] These responses demonstrate a profound disrespect and lack of understanding of medical providers' legal, ethical, and moral obligations to care for women with disabilities. Sadly, this is the rule rather than the exception in health care facilities across New York City.

New York City has a long road ahead to ensure that all of its healthcare facilities provide accessible care to people with disabilities. Barriers and biases that block men and women with all types of disabilities from obtaining accessible care, must be eliminated in health care settings of all sizes and types. But the accomplishment of ICS's projects – the long overdue accessible care for its members – begs for replication. Medical providers and policymakers have a legal and moral obligation to ensure that New Yorkers are not subjected to inferior care on account of their disability.

"Solutions will require multiple approaches, including ensuring that facilities and equipment are fully accessible to women with diverse disabilities and that clinicians are trained in "disability competency." Trainers in disability awareness could learn volumes from programs such as Independence Care System, with its multifaceted care model that ensures women with disabilities receive the services they desire and need to maximize their health and quality of life."

– Lisa I. Iezzoni, MD, MSc, Director of the Mongan Institute for Health Policy at Massachusetts General Hospital & Professor of Medicine at Harvard Medical School

Recommendations to Providers & Policymakers

People with disabilities encounter a multitude of obstacles to comprehensive, quality health care in facilities of all sizes in New York City. These barriers include architectural and communication barriers, inaccessible equipment, and provider bias. The effects of these obstacles to care are profound; inaccessible health care negatively impacts nearly every aspect of an individual's life, and leads to significant disparities.

New York City hospitals and clinics have an opportunity to take the lead nationwide in providing accessible health care, in compliance with applicable law, to their patients with disabilities. Public and private medical providers, city and state lawmakers, and state agencies all have key roles to play in ending healthcare disparities for people with disabilities. We recommend the following actions be taken immediately:

New York City Medical Provider Recommendations

Medical providers must develop and implement a comprehensive plan for providing accessible care to people with disabilities. The plan should include:

- **The creation and dissemination of a system-wide non-discrimination policy, with accompanying protocols and procedures.** Facilities must come into compliance with disability anti-discrimination laws by providing patients with disabilities with equal access to care. Facility and system administrators must create and implement a policy and accompanying protocols to ensure compliance at all levels. Facilities must also designate a point person to coordinate and ensure the implementation of such policies and protocols. Such protocols must include a grievance procedure for patients with disabilities who are denied accessible care.
- **The development and implementation of mandatory, system-wide disability competency provider trainings.** Facilities must develop a mandatory system-wide training, or series of trainings, in consultation with experts in disability competency. Such training/s must cover the following core concepts: disability awareness and sensitivity; overarching legal obligations to provide accommodations; protocols for positioning and transferring patients with disabilities; the requirement to provide additional staff as needed for certain procedures and tests; and the requirement to fully treat and counsel patients with disabilities, including about basic health information such as when and how to obtain preventative screenings.

"Some of our members have trouble breathing when they have to lay completely flat. They just can't breathe like that. So it is traumatic when they are on a regular table. The table at Morrisania, has a head rest that raises so they can breathe and relax. It is a relief for them that they can finally breathe at a doctor's office. The table also has side rails so women do not feel like they are going to fall off. All of these things make it possible to do the test. The table is one of the most important things."

— Jane Nietes, Nurse Educator, Independence Care System

- **The acquisition of accessible equipment and removal of communication and architectural barriers.** Providers must purchase accessible equipment, including mammography machines, weight scales, examination tables, and Hoyer lifts. Providers must also remove existing barriers, such as by widening doors and installing grab bars, and providing sign language interpreters and materials in alternative print. Finally, providers must utilize positioning aids and supports to assist women with disabilities as needed to facilitate screenings and procedures.
- **Coordinate care and maintain good data and records.** Providers must ensure that the process of scheduling appointments, requesting and providing accommodations runs smoothly for patients with disabilities. Such process shall include a functional assessment prior to the appointment, which would then be stored in the patient's file and referenced prior to each appointment.

"The provision of culturally competent care is required by current laws, regulations and accreditation agencies' standards. At HHC, we ascribe to the belief that the provision of culturally competent care:

•Is an essential component of HHC's mission, vision and values;

•Leads to improvements in quality and patient safety;

•Is necessary to accommodate changing patient and neighborhood demographics;

•Reduces health disparities; and most importantly,

•Is the right thing to do."

— New York City Health and Hospitals Corporation
Comments before New York City Council Committees on Health and Civil Rights
Delivered by Caroline M. Jacobs, Senior Vice President, Safety and Human Development

New York City Health & Hospitals Corporation (HHC) Recommendations

In addition to the aforementioned recommendations that pertain to medical providers, HHC should:

- **Convene a task force to develop detailed guidance on ensuring accessibility in healthcare facilities in compliance with existing law.** HHC should assemble a task force to develop technical assistance to guide facilities on how to ensure their programs and services are accessible. The task force should include a representative from each facility, experts, stakeholders, and people with disabilities who can advise on effective policy and training, accessible equipment procurement, architectural modifications, accessible communication, and disability specific medical protocols (e.g. follow-up after mammograms that produce limited views due to inaccessibility of screening). The task force should issue reports, guidance, and recommendations to help facilities comply with disability rights laws in a consistent manner. Each facility's representative should ensure implementation of the guidance issued by the taskforce. Quarterly, the facility coordinators should meet to review best practices, implementation, and discuss innovative approaches to making their facilities accessible. Stakeholders, including people with disabilities and the public at large, should also be invited to participate in the quarterly meetings to provide their feedback and suggestions.
- **Develop and disseminate a patient and provider survey regarding the accessibility of HHC facilities and services.** The survey should assess the knowledge of providers about their obligations under the ADA and state and city anti-discrimination laws. Providers should be asked about all types of accommodations and how they provide care to people with disabilities. Patients should also be surveyed to understand whether they are receiving the care they need. HHC should use this data to target, through trainings, the gaps in knowledge that staff may display, as well as to inform facilities about ways in which they must make services accessible.

New York City Council Recommendations

- **Pass a comprehensive resolution urging New York City hospitals and medical providers to comply with existing federal, state, and local disability anti-discrimination laws.** The City Council is uniquely situated to communicate the importance of providing accessible health care to all New York City residents, including individuals with disabilities. The City Council should pass a resolution which:
  - o *Directs New York City medical providers to, at a minimum:*
    - Comply with existing federal, state, and city laws regarding people with disabilities, as well as relevant regulations and guidance as issued
    - Develop a guiding non-discrimination policy, designate a point person to coordinate its implementation, and create protocols and procedures staff must follow to ensure facility accessibility
    - Eliminate existing communication, attitudinal, and physical barriers to care, alter physical space as necessary, and purchase accessible equipment
    - Provide mandatory disability competency, awareness, and sensitivity training
    - Notify patients with disabilities of their rights under disability anti-discrimination laws and how to file a complaint
  - o *Directs the New York City Health and Hospitals Corporation to, at a minimum, in addition to the aforementioned recommendations:*
    - Convene a task force to develop detailed guidance for health care facilities on how to make services accessible in compliance with existing law
  - o *Urges the New York State Department of Health to, at a minimum:*
    - Issue and enforce detailed guidance to healthcare facilities as to their legal obligations regarding making programs and facilities accessible to people with disabilities
    - Create a robust and accessible complaint process with defined follow-up procedures
    - Amend facility requirements on training and intake to include disability
  - o *Urges the New York State legislature to, at a minimum:*
    - Pass legislation requiring that medical facilities procure accessible medical equipment in compliance with anti-discrimination laws and regulations
    - Issue notice requirements for all healthcare facilities to notify patients of their right to accommodations and accessible care

"I would hope that the doctor would see me as a person, but I think they just see the wheelchair. They don't see us as people because they think it will take more time. But with [the ICS Project gynecologist], I automatically felt more comfortable. I felt like she actually saw me as a woman coming for an appointment to be healthy."

—M. Lyons, Member, Independence Care System

- **Include funding in the budget, with terms and conditions, to assist capital improvements at HHC facilities that are designed to increase accessibility for people with disabilities.** At a minimum, HHC facilities should procure Hoyer lifts and, accessible mammography machines, exam tables, and weight scales. As a "term and condition" of HHC funding, the City Council should require that HHC procure all goods in compliance with anti-discrimination laws.
- **City Council should convene annual oversight hearings on the accessibility of medical services and the needs of people with disabilities.** Annual hearings on this issue should be used to assess HHC's progress toward making facilities accessible and whether private providers are serving individuals with disabilities equally. Facilities should be asked to provide information regarding staff training, procurement policies, compliance with the ADA, and the services provided to people with disabilities.

"People jokingly tell me that they would gladly keep the weight from their youthful pasts. Exact weight, however, can matter. A woman whom I interviewed for a research project on women with physical disabilities who develop breast cancer has used a wheelchair since a spinal cord injury in her late teens. Twenty-five years later with breast cancer, her oncologist needed to know her weight to set her chemotherapy dose; however, the academic medical center where she received care did not have an accessible scale. To find her weight, her oncologist scooped her up from her wheelchair and stepped onto a scale holding her in his arms."

— Lisa I. Iezzoni, MD, MSc, Director of the Mongan Institute for Health Policy at Massachusetts General Hospital & Professor of Medicine at Harvard Medical School

"ICS's GYN project was the first time I've been accurately weighed."

—M. Lyons, Member, Independence Care System

<u>New York State Department of Health Recommendations</u>

- **Issue a detailed administrative directive to all medical facilities regarding their obligation to provide accessible services to people with disabilities, and ensure facility compliance with said directive and disability anti-discrimination laws.** DOH should issue a detailed directive to medical facilities operating in NYS instructing them on how to come into compliance with disability anti-discrimination laws by making facilities physically accessible, providing reasonable accommodations, and training staff on disability competency and techniques for providing assistance to patients with disabilities. The directive should also include clarification that positioning and support aids are not considered "restraints" when used to position patients with disabilities during routine exams or procedures. The directive should instruct providers to follow the DOJ and Access Board's regulations and guidance regarding access to medical care for people with disabilities as issued. DOH should use its authority to ensure compliance with anti-discrimination laws and the specific components of this directive.
- **Create a robust and accessible complaint process with defined follow-up procedures.** DOH should create and implement an accessible complaint process that includes a clearly defined follow-up procedure, including investigation of non-compliant facilities. Complaints received through such process should be reviewed when making decisions regarding

"Being weighed has always been an issue. They say, 'let's do it approximately.' Before they prescribe medication they should know my weight, but sometimes they'll say 'let's try this dose and you can come back to change it if we need to.' Sometimes they'll just ask how long ago I was weighed and how much, and just write that down instead of weighing me. I'm not sure if it's because they don't have the right equipment, or because they don't want to be bothered. When you're a disabled person and you go to get care, it will take more time. But we live in a society where everything has to be done quickly. Unfortunately, it's going to take an extra minute for people with disabilities."

– M. Lyons, Member, Independence Care System

the selection of facilities for compliance review. Information about the complaint process, including how and where to file a complaint and the process for investigation, should be conspicuously posted on the DOH's website and on materials distributed to patients.

- **Amend facility requirements on training and intake to include disability.** DOH should amend existing requirements for intake processes at in- and out-patient facilities to include a disability accommodations needs assessment. This assessment should give the patient an opportunity to identify and request reasonable accommodations so the facility can take steps to make care accessible (i.e. if patient identifies that she cannot hold her hands above her head, facility will note that positioning aides or extra technologist must be available for exam). DOH should also amend facility quality assurance training requirements to include mandatory ongoing disability competency training for all staff. DOH should exercise its authority to the fullest extent possible to ensure that medical providers practicing in NYS are properly trained on how to provide equal care to people with disabilities. As mentioned in the "Medical Providers Recommendations," such training/s, which should be developed by the facility, must cover several concepts that are fundamental to providing accessible care.

<u>New York State Legislature Recommendations</u>

- **Pass legislation that requires all medical facilities to provide notice to patients of their rights to accessible care.** Medical facilities must be required to clearly post throughout facilities, and make available in accessible formats, notices regarding the availability of – and process by which to request – disability accommodations. This notice should be conspicuously posted on each healthcare facility's website, in e-mail notifications to patients, and in brochures and other patient materials.
- **Pass legislation requiring procurement of accessible medical equipment by healthcare facilities.** The legislature should pass legislation requiring that all medical equipment procured by healthcare facilities and clinics comply with anti-discrimination laws and regulations, and that all newly purchased equipment follow principles of universal design and be accessible to people with disabilities.

"It's important because my mother had breast cancer and if I don't get that mammogram I could get cancer and not know it. If I get the mammogram maybe I could catch it in time. I like to have my mammogram every year."

– Esther J., Member, Independence Care System

Endnotes

[1] *See, e.g.*, NAT'L COUNCIL ON DISABILITY, THE CURRENT STATE OF HEALTH CARE FOR PEOPLE WITH DISABILITIES (2009), http://www.ncd.gov/rawmedia_repository/0d7c848f_3d97_43b3_bea5_36e1d97f973d?document.pdf; *see also*, JUDY PANKO REIS ET AL., IT TAKES MORE THAN RAMPS TO SOLVE THE CRISIS OF HEALTHCARE FOR PEOPLE WITH DISABILITIES 7 (2004), www.tvworldwide.com/events/hhs/041206/PPT/RIC_whitepaperfinal82704.pdf.

[2] *See, e.g.*, M. A. Nosek and C. A. Howland, *Breast and Cervical Cancer Screening Among Women with Physical Disabilities*, 78 ARCHIVES OF PHYSICAL MED. & REHABILITATION S39 (1997).

[3] *See, e.g.*, Ellen P. McCarthy et al., *Disparities in Breast Cancer Treatment and Survival for Women with Disabilities*, 145(9) ANNALS OF INTERNAL MED. 637 (2006).

[4] REIS ET AL., *supra* note 1, at xiii ("If the age-specific prevalence of major chronic conditions remains unchanged, the absolute number of Americans with functional limitations will rise by more than 300 percent by 2049.").

[5] In New York City, only 4% of children between 5 and 17 years old have a disability, while well over a third of the population over 65 years old have a disability. U.S. CENSUS BUREAU, 2011 AM. CMTY. SURVEY, DISABILITY CHARACTERISTICS NEW YORK CITY, NEW YORK, tbl.S1810 (2011).

[6] N.Y.C. DEP'T OF CITY PLANNING, NEW YORK CITY POPULATION PROJECTIONS BY AGE/SEX & BOROUGH, 2000-2030 (2006).

[7] U.S. CENSUS BUREAU, *supra* note 5, at tbl.S1810.

[8] *Id.* at tbl.B18135.

[9] *Id.* at tbl.B18130.

[10] *Id.* at tbl.B1811.

[11] *Id.* at tbl.B18130.

[12] Independence Care System, 2011 Community Breast Health Grantee: Final Report 2 (Apr. 30, 2012) (unpublished grant report) (on file with Independence Care System) [hereinafter Independence Care System, Final Report].

[13] AM. MED. ASS'N, CODE OF MEDICAL ETHICS [hereinafter CODE OF MEDICAL ETHICS], *available at* http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/principles-medical-ethics.page (last visited Oct. 22, 2012).

[14] M.T. Neri & T. Kroll, *Understanding the consequences of access barriers to health care: experiences of adults with disabilities*, 25 DISABILITY & REHAB. 85, 94 (2003).

[15] In addition to complaints received through its intake line, NYLPI has heard stories of inaccessible care from individuals with disabilities during education and outreach events. ICS has received complaints from its members through group discussions, education and outreach events, and from the participants in the Women's Health Access Program.

[16] *See* Catherine Leigh Graham & Joshua R. Mann, *Accessibility of Primary Care Physician Practice Sites in South Carolina for People with Disabilities*, 1 DISABILITY & HEALTH J. 209, 212 (2008).

[17] JUNE ISAACSON KAILES ET AL., CTR. FOR DISABILITY ISSUES & THE HEALTH PROFESSIONS, HEALTH CARE (CLINIC / OUT-PATIENT) FACILITIES ACCESS 7, 8, 13 (2d ed. 2009), http://www.cdihp.org/briefs/4.%20Brief-Health%20Care%20(outpatient_clincs)%20Facilites%20-%20FINAL%20Edition%202_1.5.09.pdf.

[18] NYLPI has heard such complaints expressed by numerous New Yorkers, particularly when it comes to specialty care. These barriers can be further compounded by the absence of accessible providers within provider networks or HMOs.

[19] DISABILITY RIGHTS EDUC. & DEFENSE FUND, DISABILITY HEALTHCARE ACCESS BRIEF 1-2, http://www.dredf.org/healthcare/Access_Brief.pdf.

[20] *See, e.g.*, Lisa I. Iezzoni et al., *Physical Access to Barriers to Care for Diagnosis and Treatment of Breast Cancer Among Women with Mobility Impairments*, 37 ONCOLOGY NURSING FORUM 711, 714 (2010) [hereinafter Iezzoni, et al., *Physical Access to Diagnosis and Treatment of Breast Cancer*]. When accessible tables are not available in a facility, doctors may also be reluctant to suggest necessary procedures or fully examine a patient. Kristi L. Kirschner et al., *Structural Impairments That Limit Access to Health Care for Patients with Disabilities*, 297 JAMA 1121, 1121 (2007).

[21] JUNE ISAACSON KAILES ET AL., CTR. FOR DISABILITY ISSUES & THE HEALTH PROFESSIONS, IMPORTANCE OF ACCESSIBLE WEIGHT SCALES (2004).

[22] *See, e.g.*, U.S. DEP'T OF JUSTICE, AMERICANS WITH DISABILITIES ACT: ACCESS TO MEDICAL CARE FOR INDIVIDUALS WITH MOBILITY DISABILITIES 18 [hereinafter U.S. DEP'T OF JUSTICE, ACCESS TO MEDICAL CARE], *available at* http://www.ada.gov/medcare_ta.htm (last visited Oct. 22, 2012) ("A patient's weight is essential medical information used for diagnostics and treatment. Too often, individuals who use wheelchairs are not weighed at the doctor's office or hospital, even though patients without disabilities are routinely weighed, because the provider does not have a scale that can accommodate a wheelchair.").

[23] JUNE ISAACSON KAILES, CTR. FOR DISABILITY ISSUES & THE HEALTH PROFESSIONS, REHAB. ENGINEERING RES. CTR. ON ACCESSIBLE MED. INSTRUMENTATION, 5 "G'S:" GETTING ACCESS TO HEALTH CARE FOR PEOPLE WITH DISABILITIES (v.1 2008), http://www.cdihp.org/Five%20Gs%20apr21.pdf.

[24] Graham & Mann, *supra* note 16, at 212.

[25] *See* Kirschner et al., *supra* note 20, at 1122.
[26] NAT'L COUNCIL ON DISABILITY, *supra* note 1, at 23 (citing HENRY J. KAISER FAMILY FOUND., HEALTHCARE FOR PEOPLE WITH DISABILITIES (2004), http://www.kff.org/medicaid/7202.cfm).
[27] NYLPI has represented deaf clients who have encountered numerous communication barriers in all types of health care facilities, including at hospitals and rehabilitation facilities in New York City.
[28] Lisa I. Iezzoni et al., *Communicating About Health Care: Observations from Person Who Are Deaf or Hard of Hearing*, 140 ANNALS OF INTERNAL MEDICINE 356, 360 (2010).
[29] NAT'L COUNCIL ON DISABILITY, *supra* note 1, at 71 (citing Helen Margellos-Anast et al., *Cardiovascular disease knowledge among culturally Deaf patients in Chicago*, 42 PREVENTIVE MED. 235 (2006); SINAI HEALTH SYS. AND ADVOCATE HEALTH CARE, IMPROVING ACCESS TO HEALTH AND MENTAL HEALTH FOR CHICAGO'S DEAF COMMUNITY: A SURVEY OF DEAF ADULTS (2004)).
[30] NAT'L COUNCIL ON DISABILITY, *supra* note 1, at 71 (citing M.F. Goldstein, et al., *An HIV Knowledge and Attitude Survey of Deaf U.S. Adults*, 22(1) DEAF WORLDS 163 (2006)).
[31] Aging is one of the leading causes of vision loss. NAT'L COUNCIL ON DISABILITY, *supra* note 1, at 73 (citing R.N. Bailey et al., *Visual Impairment and Eye Care Among Older Adults – Five States, 2005*, 55 MORBIDITY & MORTALITY WEEKLY REPORT 1321, 1321–26 (2006)). As the population ages, the number of people who are blind and the number of people with vision impairments living in the U.S. is projected to increase by an astonishing 70-percent between 2009 and 2020. NAT'L COUNCIL ON DISABILITY, *supra* note 1, at 73 (citing Nat'l Eye Inst., *Causes and Prevalence of Visual Impairment Among Adults in the United States*, 122 ARCHIVES OF OPHTHALMOLOGY 477, 477-85 (2004)).
[32] *See* EQUAL RIGHTS CTR., ILL-PREPARED: HEALTH CARE'S BARRIERS FOR PEOPLE WITH DISABILITIES 3, 22 (2011) (summarizing a national study, which revealed that "[o]nly 23 percent of doctors' offices and hospitals offered patient information in large print, and only 24 percent offered patient information in an accessible format").
[33] The doubled rates of dissatisfaction with the quality of health care received were 8.1-percent versus 4-percent, and inadequate information provided about their health conditions were 11-percent versus 6-percent. Bonnie L. O'Day et al., *Improving Health Care Experiences of Persons Who Are Blind or Have Low Vision: Suggestions from Focus Groups*, 19 AM. J. OF MED. QUALITY 193, 194 (2004).
[34] NYLPI has heard such concerns expressed by New Yorkers with disabilities through its intake line and at outreach and education events.
[35] *See, e.g.*, Settlement Agreement Under the Americans with Disabilities Act Between the United States of America and Dr. Bruce Berenson, M.D., P.A. for Complaint USAO No: 2011-VO-0468/DJ No. 202-18-267, Aug. 1, 2012 [hereinafter "Berenson Settlement"], *available at* http://www.ada.gov/berenson_settle.htm (last visited Oct. 22, 2012) (addressing a complaint against a medical office for refusing to allow a patient with a disability to bring his service animal into the office).
[36] *See, e.g.*, Rolanda L. Ward et al., *Uncovering Health Care Inequalities among Adults with Intellectual and Developmental Disabilities*, 35(4) HEALTH & SOCIAL WORK 280, 286 (2010).
[37] *See* Ward et al., *supra* note 36, at 285–87.
[38] Oliver Lord et al., *Receipt of preventive medical care and medical screening for patients with mental illness: a comparative analysis*, 32 GEN. HOSP. PSYCHIATRY 519, 539 (2010).
[39] Graham Thornicroft, *Physical health disparities and mental illness: the scandal of premature mortality*, 199 BRIT. J. OF PSYCHIATRY 441, 441 (2011).
[40] *Opinion 10.01 - Fundamental Elements of the Patient-Physician Relationship*, AM. MED. ASS'N, *available at* http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion1001.page (last visited Oct. 22, 2012).
[41] NAT'L COUNCIL ON DISABILITY, *supra* note 1, at 49.
[42] Silvia Yee, Staff Attorney, Disability Rights Education and Defense Fund, Disability Discrimination in Health Care, Presented at the Jacobus tenBroek Disability Law Symposium (April 2012), at 4, http://dredf.org/healthcare/tenBroek-4-20-12.pdf.
[43] NAT'L COUNCIL ON DISABILITY, *supra* note 1, at 48 (citing Gloria L. Krahn & Charles E. Drumm, *Translating Policy Principles into Practice to Improve Health Care Access for Adults with Intellectual Disabilities: A Research Review of the Past Decade*, 13 MENTAL RETARDATION & DEVELOPMENTAL DISABILITIES RES. REVIEWS 160–68 (2007)).
[44] T.J Larsen et al., *Effective Communication with Deaf Patients and Awareness of the Americans with Disabilities Act Among Emergency Personnel: A National Study*, 34 ANNALS OF EMERGENCY MED. S24, S24 (1999).
[45] Michelle A. Larson McNeal et al., CTR. FOR DISABILITY ISSUES & THE HEALTH PROFESSIONS, PROVIDING PRIMARY HEALTH CARE FOR PEOPLE WITH PHYSICAL DISABILITIES: A SURVEY OF CALIFORNIA PHYSICIANS 8 (2002), http://www.cdihp.org/pdf/ProvPrimeCare.pdf.
[46] *Id.* at 11.
[47] *Id.*
[48] CODE OF MEDICAL ETHICS, *supra* note 13.

[49] 29 U.S.C. § 794(b)(3)(A)(ii) defines "program or activity" as "an entire corporation, partnership or other private organization, or an entire sole proprietorship, which is principally engaged in the business of providing . . . health care . . . ." *See also,* 45 C.F.R. Pt. 84, App. A, subpart a.2.

[50] *See* 42 U.S.C. § 12131(1)(A).

[51] *See* 42 U.S.C. § 12181(7) (listing entities that constitute "public accommodations"); 28 C.F.R § 36.104 (defining "place of public accommodation" and listing examples).

[52] *See Rodal v. Anesthesia Grp. of Onondaga, P.C.*, 369 F.3d 113, n.1 (2d Cir. 2004) ("New York State disability discrimination claims are governed by the same legal standards as federal ADA claims.").

[53] "Interpretations of New York state or federal statues with similar wording may be used to aid in interpretation of New York City Human Rights Law, viewing similarly worded provisions of federal and state civil rights laws as a floor below which the City's Human Rights law cannot fall, rather than a ceiling above which the local law cannot rise." N.Y.C. Local Law 85, § 1 (Oct. 3, 2005).

[54] N.Y. EXEC. LAW § 292(9) (explicitly naming clinics and hospitals); Admin. Code of the City of New York § 8-102(9).

[55] *See* 42 U.S.C. § 12102 (ADA definition of "disability"); 29 U.S.C. § 705(20) (Rehab Act definition of "individual with a disability"); N.Y. EXEC. LAW § 292(21) (State Human Rights Law definition of "disability"); Admin. Code of the City of New York § 8-102(16) (City Human Rights Law definition of "disability"). The State and City Human Rights Laws define "disability" more expansively than federal laws. *See Treglia v. Town of Manlius*, 313 F.3d 713, 723 (2d Cir. 2002) ("New York and Second Circuit cases make clear that the New York disability statute defines disability more broadly than does the ADA.").

[56] 42 U.S.C. §§ 12102(1)(B)-(C), 12102(3) (ADA, including within its definition of "disability" "a record of such an impairment" and "being regarded as having such an impairment"); 29 U.S.C. § 705(20)(B) (Rehab Act, incorporating the ADA's definition of "disability"); N.Y. EXEC. LAW § 292(21) (including within its definition of "disability" "a record of such an impairment or . . . a condition regarded by others as such an impairment"); Admin. Code of the City of New York §§ 8-102(16), 8-107(4) (including within its definition of disability "a history or record of such impairment" and defining discrimination to include discrimination based on "actual or perceived" disability); 28 C.F.R. § 35.104 (ADA Title II regulation); 28 C.F.R. § 36.104 (ADA Title III regulation).

[57] 42 U.S.C. § 12203(a); N.Y. EXEC. LAW § 296(7); Admin. Code of the City of New York § 8-107(7).

[58] 42 U.S.C. §§ 12132, 12182(b)(1)(A) (ADA Title II and Title III, respectively); 29 U.S.C. § 794(a) (Rehab Act); N.Y. EXEC. LAW § 296(2)(a) (State Human Rights Law); Admin. Code of the City of New York § 8-107(4)(a) (City Human Rights Law); 28 C.F.R. §§ 35.130(a), 35.130(b)(1)-(2) (Title II regulations); 28 C.F.R. §§ 36.201(a) (Title III regulation).

[59] 42 U.S.C. § 12182(b)(2)(A)(iii)-(iv) (Title III); N.Y. EXEC. LAW §§ 296(2)(c)(iii)-(iv) (State Human Rights Law); Admin. Code of the City of New York § 8-102(18) (City Human Rights Law); 28 C.F.R. § 36.304 (Title III regulation). In addition, new construction at health care facilities must comply with the ADA Accessibility Guidelines for Buildings and Facilities (ADAAG), which contains scoping and technical requirements for accessibility to buildings and facilities. U.S. DEP'T OF JUSTICE, 2010 ADA STANDARDS FOR ACCESSIBLE DESIGN (2010), http://www.ada.gov/regs2010/2010ADAStandards/2010ADAStandards.pdf.

[60] 28 C.F.R. § 36.304(a)-(b) (Title III regulation requiring barrier removal and listing 21 examples of barrier removal).

[61] *See* U.S. DEP'T OF JUSTICE, ACCESS TO MEDICAL CARE, *supra* note 22, at Part 4. Although medical providers are already obligated by federal, state and local law to ensure the accessibility of the health care services, the Patient Protection and Affordable Care Act of 2010 (PPACA) calls for even more detailed standards of accessible medical diagnostic equipment. *See* 42 U.S.C. § 18001 *et seq.* The PPACA amends 29 U.S.C. 791 *et seq.* (Title V of the Rehabilitation Act of 1973) by adding § 510(a) – (c), "Establishment of Standards for Accessible Medical Diagnostic Equipment," which authorizes the United States Access Board to develop new access standards for medical diagnostic equipment including "examination tables and chairs, weight scales, x-ray machines and other radiological equipment, and mammography equipment." Access Board to Set Standards for Medical Diagnostic Equipment under Health Care Reform Law, *available at* http://www.access-board.gov/news/medical-equipment.htm (last visited Oct. 22, 2012). Similarly, the Department of Justice is developing regulations for medical equipment and furniture. *See* Nondiscrimination on the Basis of Disability by State and Local Governments and Places of Public Accommodation; Equipment and Furniture, 175 Fed. Reg. 43,452 (July 26, 2010) (to be codified at 28 C.F.R. pts. 35 &36) (comment submissions available at http://www.regulations.gov/#!docketDetail;dct=FR+PR+N+O+SR+PS;rpp=10;po=0;D=DOJ-CRT-2010-0008).

[62] *See* U.S. DEP'T OF JUSTICE, AMERICANS WITH DISABILITIES ACT, ADA TITLE III TECHNICAL ASSISTANCE MANUAL COVERING PUBLIC ACCOMMODATIONS AND COMMERCIAL FACILITIES, III-7.8300 [hereinafter U.S. DEP'T OF JUSTICE, ADA TITLE III TECHNICAL ASSISTANCE MANUAL], *available at* http://www.ada.gov/taman3.html (last visited Oct. 22, 2012); U.S. DEP'T OF JUSTICE, ACCESS TO MEDICAL CARE, *supra* note 22, at Part 4.

[63] U.S. DEP'T OF JUSTICE, ACCESS TO MEDICAL CARE, *supra* note 22, at 11-15.

[64] *Id.* at 19.

[65] *Id.* at 4,19.
[66] 42 U.S.C. § 12182(2)(A)(iii) (Title III); N.Y. EXEC. LAW §§ 296(2)(c)(ii) (State Human Rights Law); Admin. Code of the City of New York § 8-107(15) (City Human Rights Law); 28 C.F.R. § 35.160(b) (Title II regulation); 28 C.F.R. § 36.303 (Title III regulation).
[67] 42 U.S.C. § 12103(1) (ADA); N.Y. EXEC. LAW §§ 296(2)(d)(ii) (State Human Rights Law); 28 C.F.R. § 35.104 (Title II regulation); 28 C.F.R. § 36.303(b) (Title III regulation).
[68] N.Y. EXEC. LAW §§ 296(2)(d)(ii) (State Human Rights Law); 28 C.F.R. § 35.104; 28 C.F.R. § 36.303(b).
[69] 42 U.S.C. § 12182(b)(2)(A)(iii) (Title III); N.Y. EXEC. LAW §§ 296(2)(c)(ii) (State Human Rights Law); Admin. Code of the City of New York § 8-102(18) (City Human Rights Law); 28 C.F.R. § 35.164 (Title II regulation); 28 C.F.R. § 36.303(a) (Title III regulation).
[70] 28 C.F.R. § 35.160 (Title II regulation); 28 C.F.R. § 36.303(c)(1) (Title III regulation).
[71] 28 C.F.R. § 35.160(c)(1) (Title II regulation); 28 CFR § 36.303(c)(2) (Title III regulation).
[72] 28 C.F.R. § 35.130(f) (Title II regulation); 28 C.F.R. § 36.301(c) (Title III regulation).
[73] 42 U.S.C. § 12182(b)(2)(A)(ii) (Title III); 28 C.F.R. § 35.130(b)(7) (Title II regulation); 28 C.F.R. § 36.302 (Title III regulation).
[74] 28 C.F.R. § 35.136(a) (Title II regulation); 28 C.F.R. § 36.302(c)(1) (Title III regulation); *see also* U.S. DEP'T OF JUSTICE, ADA TITLE III TECHNICAL ASSISTANCE MANUAL, at III-4.2300, *supra* note 62.
[75] *See* U.S. DEP'T OF JUSTICE, ACCESS TO MEDICAL CARE, *supra* note 22, at 19.
[76] *See id.* at 16.
[77] Jock Hoffman, *Are You Ready?*, STRATEGIES FOR PATIENT SAFETY, ACADEMIC GRP. (April 2010), *available at* http://www.academicins.com/articles/SPS-academic-4-2010.html (last visited Oct. 22, 2012) (emphasis added).
[78] 42 U.S.C. § 794(c) (Rehab Act); 42 U.S.C. § 12133 (Title II, incorporating the enforcement provisions of the Rehab Act); 42 U.S.C. § 12188 (Title III); N.Y. EXEC. LAW § 297 (State Human Rights Law); Admin. Code of the City of New York §§ 8-109, 8-502 (City Human Rights Law); 28 C.F.R. § 35,170 (Title II regulation); 28 C.F.R. § 36.502 (Title III regulation). Note that medical providers might also be liable for negligence and/or medical malpractice in cases where they fail to provide safe, accessible care.
[79] *See* Settlement Agreement Between the United States of America and Medical Specialists of the Palm Beaches, Inc., Sept. 28, 2012 [hereinafter "Medical Specialists of the Palm Beaches Settlement"], *available at* http://www.ada.gov/mspb-settlement.htm (last visited Oct. 22, 2012) (requiring medical provider to provide an accessible scale, as well as training for staff on ADA requirements and transferring patients with disabilities to an examination or imaging table); Settlement Agreement Between the United States of America and Marin Magnetic Imaging, July 21, 2006, at ¶¶ 4, 9 [hereinafter "Marin Magnetic Imaging Settlement"], *available at* http://www.ada.gov/marinmagim.htm (last visited Oct. 22, 2012) (summarizing investigation in which U.S. DOJ determined that medical office failed to reasonably accommodate a patient with a disability by "not providing him the equipment and/or assistance he needed to get onto the exam table, in violation of Title III of the ADA" and requiring that the medical office pay $2000 to the patient); Settlement Agreement Between the United States of America and Valley Radiologists Medical Group, Inc., Nov. 2, 2005, at ¶ 4 [hereinafter "Valley Radiologists Settlement"], *available at* http://www.ada.gov/vri.htm (last visited Oct. 22, 2012) (summarizing investigation in which U.S. DOJ determined that medical office failed to reasonably accommodate a patient with a disability by "not providing her the assistance she needed to get onto the examination table, in violation of Title III of the ADA"); Settlement Agreement Between the United States of America and Exodus Women's Center, Inc., Apr. 26, 2005, at ¶ 4 [hereinafter "Exodus Settlement"], *available at* http://www.ada.gov/exodus.htm (last visited Oct. 22, 2012) (same); Settlement Agreement Between the United States of America and Dr. Robila Ashfaq, Jan. 10, 2005, at ¶ 4 [hereinafter "Ashfaq Settlement"], *available at* http://www.ada.gov/drashfaq.htm (last visited Oct. 22, 2012) (same); *see also* Settlement Agreement Among the United States of America, Plaintiffs Equal Rights Center, Dennis Christopher Butler, Rosemary Ciotti, George Aguehounde, and Marsha Johnson, and Washington Hospital Center, Nov. 1, 2005 [hereinafter "Washington Hospital Settlement"], *available at* www.ada.gov/whc.htm (last visited Oct. 22, 2012) (requiring hospital to implement extensive changes in policies, practices, and medical equipment). Private settlement agreements have also been reached in actions involving inaccessible medical facilities across the country. *See, e.g.*, Settlement Agreement: Metzler et al. v. Kaiser Foundation Health Plan, Inc. et al., March 2001, *available at* http://www.dralegal.org/downloads/cases/metzler/settlement.pdf (last visited Oct. 22, 2012); Settlement Agreement Between UCSF Medical Center and August Longo, *available at* http://lflegal.com/2008/09/ucsf-settlement-agreement/ (last visited Oct. 22, 2012). Information regarding other medical access settlement agreements can be found on The Barrier Free Health Care Initiative's website *at* http://thebarrierfreehealthcareinitiative.org/?page_id=16 (last visited Oct. 22, 2012).
[80] *See, e.g.*, Settlement Agreement Between the United States of America and Northshore University Health Systems, June 25, 2012 [hereinafter "NorthShore Settlement"], *available at* http://www.ada.gov/northshore-uni-sa.htm (last visited Oct. 22,

2012) (requiring hospital to pay $46,990.00 to complainants' heir for hospital's failure to provide sign language interpreters on three occasions). A medical provider's failure to provide for effective communication could result in the failure to obtain informed consent from a patient, effectively understand and diagnose a patient's medical condition, or properly explain treatment or medications. *See id.* at ¶ 30 (listing examples of circumstances in which the length or complexity of the communication warrants provision of a sign language interpreter).

[81] *See, e.g.*, Berenson Settlement, *supra* note 35, at ¶ 3 (summarizing investigation in which U.S. DOJ determined that a medical office effectively denied a person with a disability access to medical services in violation of the ADA when it "inappropriately questioned and objected to the presence of the complainant's service animal in the office's waiting area").

[82] N.Y. EXEC. LAW §§ 297(4)(c), 297(9) (State Human Rights Law); Admin. Code of the City of New York §§ 8-120, 8-502 (City Human Rights Law),

[83] *See* 42 U.S.C. § 12188(b)(2)(B) (Title III); *see e.g.*, NorthShore Settlement, *supra* note 80, at ¶ 48. *See also* N.Y. EXEC. LAW §§ 297(4)(c), 297(9) (State Human Rights Law); Admin. Code of the City of New York §§ 8-120, 8-502 (City Human Rights Law); Mary Pat Gallagher, *Jury Awards $400,000 to Deaf Patient for Denial of Interpreter Services*, N.J. L. J., Oct. 17, 2008, *available at* http://www.law.com/jsp/article.jsp?id=1202425326286&Jury_Awards_400000_to_Deaf_Patient_for_Denial_of_Interpreter_Services&slreturn=20120916114420 (last visited Oct. 22, 2012).

[84] *See* 42 U.S.C. § 12188(a)(2) (Title III). "[I]njunctive relief shall include an order to alter facilities to make such facilities readily accessible to and usable by individuals with disabilities to the extent required by this subchapter. Where appropriate, injunctive relief shall also include requiring the provision of an auxiliary aid or service, modification of a policy, or provision of alternative methods, to the extent required by this subchapter." *Id.; see also* N.Y. EXEC. LAW §§ 297(4)(c), 297(9) (State Human Rights Law); Admin. Code of the City of New York §§ 8-120, 8-502 (City Human Rights Law). *See also, e.g.*, Medical Specialists of the Palm Beaches Settlement, *supra* note 79; Berenson Settlement, *supra* note 35; Northshore Settlement, *supra* note 80; Marin Magnetic Imaging Settlement, *supra* note 79; Ashfaq Settlement, *supra* note 79; Washington Hospital Settlement, *supra* note 79; Valley Radiologists Settlement, *supra* note 79; Exodus Settlement, *supra* note 79.

[85] 42 U.S.C. § 12205 (ADA); 42 U.S.C. § 794a(b) (Rehab Act); Admin. Code of the City of New York, § 8-502(f) (City Human Rights Law).

[86] 42 U.S.C. § 12188(b)(2)(C) (Title III provision, that a court "may, to vindicate the public interest, assess a civil penalty against the entity in an amount (i) not exceeding $50,000 for a first violation; and (ii) not exceeding $100,000 for any subsequent violation"); N.Y. EXEC. LAW § 297(9) (providing for assessment of "civil fines and penalties in an amount not to exceed fifty thousand dollars, to be paid to the state by a respondent found to have committed an unlawful discriminatory act, or not to exceed one hundred thousand dollars to be paid to the state by a respondent found to have committed an unlawful discriminatory act which is found to be willful, wanton or malicious"); Admin. Code of the City of New York, § 8-404 (providing that "the trier of fact may, to vindicate the public interest, impose upon any person who is found to have engaged in a pattern or practice that results in the denial to any person of the full enjoyment of any right secured by chapter one of this title a civil penalty of not more than two hundred fifty thousand dollars").

[87] U.S. DEP'T OF HEALTH & HUMAN SERV., NAT'L INST. FOR OCCUPATIONAL SAFETY & HEALTH, AND CTRS. FOR DISEASE CONTROL & PREVENTION, SAFE HANDLING TRAINING FOR STUDENTS OF NURSING: CURRICULAR MATERIALS 6 (2009), http://www.cdc.gov/niosh/docs/2009-127/pdfs/2009-127.pdf [hereinafter HHS, SAFE HANDLING TRAINING FOR STUDENTS OF NURSING] (citing AUDREY L. NELSON ET AL., THE ILLUSTRATED GUIDE TO SAFE PATIENT HANDLING AND MOVEMENT (2009), http://www.mtpinnacle.com/pdfs/Guide-to-Safe-Patient-Handling.pdf); STAFF OF SUBCOMM. ON WORKPLACE SAFETY, SUBCOMM. ON LABOR, SUBCOMM. ON HEALTH, N.Y. STATE ASSEMBLY, SAFE PATIENT HANDLING IN NEW YORK: SHORT TERM COSTS YIELD LONG-TERM RESULTS 6 (Comm. Print 2011) [hereinafter SAFE PATIENT HANDLING IN NEW YORK]; MARTIN H. COHEN ET AL., FACILITY GUIDELINES INST., PATIENT HANDLING AND MOVEMENT ASSESSMENTS: A WHITE PAPER 18, 21-22 (Carla M. Borden, ed., 2010), http://www.dli.mn.gov/WSC/PDF/FGI_PHAMAwhitepaper_042710.pdf.

[88] SAFE PATIENT HANDLING IN NEW YORK, *supra* note 87, at 6; COHEN ET AL., *supra* note 87, at 21.

[89] SAFE PATIENT HANDLING IN NEW YORK, *supra* note 87, at 6.

[90] COHEN, ET AL., *supra* note 87, at 24 (citing A. B. de Castro, *Handle with care: The American Nurses Association's Campaign to address work-related musculoskeletal disorders*, 9(3) ONLINE J. OF ISSUES IN NURSING, 103 (2004)).

[91] JUNE ISAACSON KAILES ET AL., CTR. FOR DISABILITIES ISSUES & THE HEALTH PROFESSIONS, IMPORTANCE OF ACCESSIBLE EXAMINATION TABLES, CHAIRS AND WEIGHT SCALES 3 (2010).

[92] *See* Cohen et al., *supra* note 86, at 24 (citing J. W. Collins et al., *An evaluation of a 'best practices' musculoskeletal injury prevention program in nursing homes*, 10 INJURY PREVENTION 206 (2004); Bradley A. Evanoff et al., *Reduction in injury rates in nursing personnel through introduction of mechanical lifts in the workplace*, 44 AM. J. OF INDUS. MED. 451 (2003); Hester J. Libscomb et al., *Evaluation of direct workers' compensation costs for musculoskeletal injuries surrounding interventions to reduce patient lifting*, 69 OCCUPATIONAL & ENVTL. MED. 367 (2012); Audrey Nelson, et al., *Development and Evaluation of a Multifaceted Ergonomics Program to Prevent Injuries Associated with Patient Handling Tasks*, 43 INT'L J. OF NURSING STUDIES 717 (2006); A. Nelson & A. Baptiste, *Evidence-based practices for safe patient handling and movement*, 9 ONLINE J. OF ISSUES IN NURSING 3 (2004), http://asphp.org/wp-content/uploads/2011/05/Audrey_Nelson_Paper_on_Safe_Patient_Handling.pdf).

[93] SAFE PATIENT HANDLING IN NEW YORK, *supra* note 87, at 7 ("In nine National Institute of Occupational Safety and Health case studies, there were: 60-95-percent reduction in injuries; 95-percent reduction in workers' compensation costs; 92-percent reduction in medical/indemnity costs; as much as 100-percent reduction in lost work days (absence due to injury); 98-percent reduction in absenteeism (absence due to unreported injury)."). *See also*, HHS, SAFE HANDLING TRAINING FOR STUDENTS OF NURSING, *supra* note 87, at 6; Cohen et al., *supra* note 87, at 43 (citing Collins et al., *supra* note 92; Evanoff et al., *supra* note 92; Nelson et al., *supra* note 92; Nelson & Baptiste, *supra* note 92).

[94] U.S. DEP'T OF JUSTICE, TAX INCENTIVES FOR BUSINESSES [hereinafter U.S. DEP'T OF JUSTICE, TAX INCENTIVES FOR BUSINESSES], *available at* http://www.ada.gov/taxincent.htm (last visited Oct. 19, 2012) ("Small businesses with 30 or fewer employees or total revenues of $1 million or less can use the Disabled Access Credit."). *See also* I.R.C. § 44 (2006).

[95] U.S. DEP'T OF JUSTICE, TAX INCENTIVES FOR BUSINESSES, *supra* note 94 ("Eligible small businesses may take a credit of up to $5,000 (half of eligible expenses up to $10,250, with no credit for the first $250).").

[96] *Id.* (eligible businesses can use the credit "to offset their costs for access, including barrier removal from their facilities (e.g., widening a doorway, installing a ramp), provision of accessibility services (e.g., sign language interpreters), provision of printed material in alternate formats (e.g., large-print, audio, Braille), and provision or modification of equipment.").

[97] *Id.* ("Under Internal Revenue Code, Section 190, businesses can take a business expense deduction of up to $15,000 per year for costs of removing barriers in facilities or vehicles."). *See also* I.R.C § 190 (2006). Neither the tax credit, nor the deduction may be applied to the cost of new construction and all barrier removal must comply with federal accessibility standards. U.S. DEP'T OF JUSTICE, TAX INCENTIVES FOR BUSINESSES, *supra* note 97.

[98] *See* ME Caban, MD et al., *Mammography Use May Partially Mediate Disparities in Tumor Size at Diagnosis in Women with Social Security Disabilities*, 46(4) WOMEN AND HEALTH 1, 7 (2007).

[99] Martijn T. Groot et al., *Costs and Health Effects of Breast Cancer Interventions in Epidemiologically Different Regions of Africa, North America, and Asia*, 12 THE BREAST J. S81, S88 (2006), http://www.who.int/choice/publications/p_2006_breast_cancer.pdf.

[100] *See* Paul T. Cheung et al., *National Study of Barriers to Timely Primary Care and Emergency Department Utilization Among Medicaid Beneficiaries*, 60(1) Annals of Emergency Med. 4, 4, 7 (2012) (national study of the association between five barriers to primary care, such as limited clinic hours and lack of transportation, and emergency department usage for Medicaid and private insurance beneficiaries). This study by Cheung, et al. found that Medicaid recipients experienced more barriers to primary care than privately insured patients, and were more likely to use the emergency department. *Id.* Other barriers to primary care such as inaccessible medical offices or equipment may likewise increase emergency department usage for people with disabilities. *See also*, DISABLED WORLD, EMERGENCY DEP'T USE FOR ADULTS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES, *First North American study to look at ED use by adults with intellectual disabilities* (May 15, 2011), *available at* http://www.disabled-world.com/medical/rehabilitation/emergency-department.php#ixzz29J1QX5GE (last visited Oct. 22, 2012).

[101] *See* U.S. GOV'T ACCOUNTABILITY OFF., GAO-11-414R, HOSPITAL EMERGENCY DEPARTMENTS: HEALTH CENTER STRATEGIES THAT MAY HELP REDUCE THEIR USE 2 (2011), http://www.gao.gov/assets/130/126188.pdf (reporting the significantly higher cost of emergency department visits as compared to health center visits).

[102]

> According to estimates from the 2008 Medical Expenditures Panel Survey (MEPS), the average amount paid for a nonemergency visit to an emergency department was $792, while the average amount paid for a health center visit was $108. Similarly, the average charge for a nonemergency visit to an emergency department was 10 times higher than the charge for a visit to a health center—$2,101 compared to $203. MEPS is a set of large-scale surveys of families and individuals, their medical providers, and their employers across the United States.

Id. at n.5.

[103] Women with disabilities are significantly less likely to have a doctor recommend they receive a pap smear. Anthony Ramirez et al., *Disability and Preventive Cancer Screening: Results from the 2001 California Health Interview Survey*, 95(11) AM. J. OF PUB. HEALTH 2057, 2061 (2005). Relatedly, several studies have shown that medical providers frequently wrongly assume that women with disabilities are not sexually active. NAT'L COUNCIL ON DISABILITY, *supra* note 1, at 55-56.

[104] U.S. CENSUS BUREAU, *supra* note 5, at tbl.B18101.

[105] McCarthy et al., *supra* note 3, at 637 (cited in JUNE ISAACSON KAILES ET AL., CTR. FOR DISABILITY ISSUES & THE HEALTH PROFESSIONS, MAMMOGRAPHY: ADDRESSING EQUIPMENT DESIGN 5 (2009)).

> Women with SSDI and Medicare who had breast-conserving surgery were also less likely than other women to receive radiotherapy and axillary lymph node dissection. These women had lower survival rates from all causes and specifically from breast cancer. Explanations for such disparities could include lack of early diagnosis, lack of breast health awareness or education on the part of the woman herself, inaccessible or unreliable transportation, and cultural capacity of the treating facility. Inaccessible equipment and other physical barriers could also add to the problem.

Id.

[106] Lisa I. Iezzoni et al., *Mobility Impairments and Use and of Screening and Preventative Services*, 90(6) AM. J. OF PUB. HEALTH. 955, 957 (2000), http://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.90.6.955.

[107] Siran M. Koroukian et al., *Mental Illness and Use of Screening Mammography Among Medicaid Beneficiaries*, 42(6) AM. J. OF PREVENTATIVE MED. 606, 608 (2012).

[108] Joanne E. Wilkinson et al., *'It's Easier Said Than Done': Perspectives on Mammography from Women with Intellectual Disabilities*, 9 ANNALS OF FAMILY MED. 142, 143 (2011) (citing N. Davies & M. Duff, *Breast cancer screening for older women with intellectual disabilities living in community group homes,* 45 J. INTELLECTUAL DISABILITY RES. 253 (2001)).

[109] Joann M. Thierry, *Observations from the CDC: Increasing Breast and Cervical Cancer Screening among Women with Disabilities*, 9(1) J. OF WOMEN'S HEALTH & GENDER-BASED MED. 9, 9 (2000) (citing Centers for Disease Control and Prevention, *National breast and cervical early detection program*, 45 MMWR. 484 (1999)).

[110] INDEPENDENCE CARE SYSTEM, BREAST CANCER SCREENING PROJECT FOR WOMEN WITH PHYSICAL DISABILITIES: A REPORT ON PRELIMINARY FINDINGS, APRIL 1, 2008 – MARCH 31, 2010. 2 (2011), http://www.icsny.org/sitemanagement/wp-content/uploads/2011/03/FINAL-KOMEN_report.pdf [hereinafter INDEPENDENCE CARE SYSTEM, BREAST CANCER SCREENING PROJECT]. ICS was also a recipient of the Susan G. Komen Grantee of the Year Award in 2012.

[111] Many frequently used mammography machines are inaccessible to women with physical disabilities. *See* INDEPENDENCE CARE SYSTEM, BREAST CANCER SCREENING PROJECT, *supra* note 110, at 5.

[112] Depending on the severity of the disability, ICS found in its project that between 12%-42% of women with disabilities needed an additional technologist to receive a mammogram, and the time required for the test ranged from 19 to 33 minutes. INDEPENDENCE CARE SYSTEM, BREAST CANCER SCREENING PROJECT, *supra* note 110, at 3; Independence Care System, Final Report, *supra* note 12, at App. A-1. *See also* Iezzoni, et al., *Physical Access to Diagnosis and Treatment of Breast Cancer*, *supra* note 20, at 714.

[113] Telephone Interview with Jane D. Nietes, Nurse Educator, Independence Care System (Oct. 9, 2012) [hereinafter Telephone Interview with Jane D. Nietes (Oct. 9, 2012)].

[114] Telephone Interview with Jane D. Nietes (Oct. 9. 2012), *supra* note 113.

[115] Telephone Interview, Member, Independence Care System (Oct. 4, 2012) [hereinafter Independence Care System Member Interview].

[116] NAT'L COUNCIL ON DISABILITY, *supra* note 1, at 58-59.

[117] Telephone Interview with Jane D. Nietes (Oct. 9, 2012), *supra* note113.

[118] Telephone Interview with Jane D. Nietes (Oct. 9, 2012), *supra* note113; Telephone Interview with Jane D. Nietes, Nurse Educator, Independence Care System (Oct. 21, 2012) [hereinafter Telephone Interview with Jane D. Nietes (Oct. 21, 2012)].

[119] INDEPENDENCE CARE SYSTEM, BREAST CANCER SCREENING PROJECT, *supra* note 110, at 4; *see also* Telephone Interview with Jane D. Nietes (Oct. 9, 2012), *supra* note 113.

[120] INDEPENDENCE CARE SYSTEM, BREAST CANCER SCREENING PROJECT, *supra* note 110, at 4.

[121] Telephone Interview with Jane D. Nietes (Oct. 9, 2012), *supra* note 113.

[122] Telephone Interview with Jane D. Nietes (Oct. 21, 2012), *supra* note 118.

[123] Telephone Interview with Jane D. Nietes (Oct. 9, 2012), *supra* note 113; Telephone Interview with Jane D. Nietes (Oct. 21, 2012), *supra* note 118.

[124] Telephone Interview with Jane D. Nietes (Oct. 21, 2012), *supra* note 118.

[125] *Id.*

[126] Telephone Interview with Jane D. Nietes (Oct. 9, 2012), *supra* note 113.

[127] Independence Care System Member Interview, *supra* note 115.

[128] INDEPENDENCE CARE SYSTEM, BREAST CANCER SCREENING PROJECT, *supra* note 110, at App. B-2.

[129] Telephone Interview with Jane D. Nietes (Oct. 21, 2012), *supra* note 118.

[130] Independence Care System, Final Report, *supra* note 12, at App. A-2.

[131] INDEPENDENCE CARE SYSTEM, BREAST CANCER SCREENING PROJECT, *supra* note 110, at 5.

[132] *See* 42 U.S.C. § 290ii; 42 C.F.R § 482.13(e); N.Y. COMP. CODES R. & REGS. TIT. 10 § 405.7(5).

[133] 42 U.S.C. § 290ii(d)(1)(A) defines restraints as "any physical restraint that is a mechanical or personal restriction that immobilizes or reduces the ability of an individual to move his or her arms, legs, or head freely, *not including devices*, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, *or any other methods that involves the physi holding of a resident for the purpose of conducting routine physical examinations or tests* or to protect the resident from falling out of b or to permit the resident to participate in activities without the risk of physical harm to the resident." (emphasis added). 42 C.F.R. § 482.13(e)(1)(i)(C) states that: "[a] restraint does not include devices, such as orthopedically prescribed devices, surg dressings or bandages, protective helmets, *or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests*, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm" (emphasis added). 10 NYCRR § 405.7(b)(5) limits the use of restraints "to those patient restraints authorized in writing by a physician after a personal examination of the patient, for a specified and limited period of time to protect the patient from injury to himself or to others."

[134] INDEPENDENCE CARE SYSTEM, BREAST CANCER SCREENING PROJECT, *supra* note 110, at 4.

CHCANYS DEFINING NEW DIRECTIONS
Community Health Care Association of New York State www.chcanys.org

COMMUNITY HEALTH CENTER FQHC QUALITY

New York City Council Health Committee

Preliminary Budget Hearing

March 23, 2015

Thank you for the opportunity to provide testimony on the Preliminary Budget Proposal. My name is Beverly Grossman and I am the Senior Policy Director of CHCANYS, the State's Primary Care Association for Federally Qualified Health Centers.

CHCANYS: Because Community Health Care is Primary

CHCANYS serves as the voice of community health centers as leading providers of primary care in New York State. We work closely with more than 33 Federally Qualified Health Centers (FQHCs) that operate 370 sites throughout New York City. Community health centers are located in medically underserved areas and provide high-quality, cost effective primary care to anyone seeking care, regardless of their insurance status or ability to pay. Each FQHC is governed by a consumer-majority board of directors who seek to identify and prioritize the services most needed by their communities.

FQHCs offer unique benefits to all communities, particularly those who have been underserved and are low income, including a model of patient-centered care that is demonstrably associated with improved outcomes and reduced costs. FQHCs are designed to be fully integrated patient-centered medical homes, providing mental health, oral health and health promotion/disease prevention services as required components of a comprehensive primary care setting. The provision of service to all, regardless of ability to pay, and demonstrated formal affiliations with specialty and hospital providers to allow "one stop shopping" for health care has been the hallmark of the FQHC model for fifty years.

Patient empowerment is an important part of the quality improvement approach at FQHCs, as chronic disease prevention and management is a cornerstone of this model. The use of practice management technology at FQHCs became prevalent in the early 1990s and a decade later

FQHCs began incorporating electronic health records in their practices. Between 2006 and 2010, CHCANYS received over $6 million from the City Council to fund hardware purchases for 30 NYC health centers to support implementation of electronic health records. Thanks in part to this investment by the City Council, by 2013 96% of New York's FQHCs had implemented practice management and electronic health systems at all service locations. FQHCs lead the nation in adoption of fully integrated technology systems and the accreditations and recognitions made possible by their adoption. The move from volume to value is as much a charge at FQHCs as anywhere else, since FQHC delivery systems must be competitive, sustainable, and capable of leading and taking risk in the larger health system.

FQHCs are central to New York City's health care safety net, serving over 972,000 patients annually, of which nearly 300,000 are under eighteen years old and 38,000 of whom were seen at FQHC-sponsored school based health centers. Three quarters of patients seen in New York City's FQHCs in 2013 were living at or below 100% of the poverty level or $23,550 for a family of four in that year. Over 63,000 patients were homeless. Twenty six percent of patients were best served in a language other than English. Over 80 percent of patients belonged to racial or ethnic minority groups and nineteen percent were uninsured, not covered by any public or private insurance program.

Specific Comments on 2015 Preliminary Budget

New York City has a severe shortage of primary care. Twenty-six NYC neighborhoods are federally designated primary care shortages areas.[i] The mismatch of supply and demand for primary care is particularly concerning given the poor financial condition of several hospitals in primary care shortage areas.[ii] Hospital emergency departments (EDs) have become significant substitutes for primary care capacity for low-income populations in NYC.[iii] Between 2011 and 2012, Medicaid enrollees made over 2.3 million visits to hospital EDs for conditions that could have been treated in a primary care or outpatient setting.[iv] Primary care access is the foundation of chronic disease management, without which health outcomes worsen and healthcare costs increase.[v] In 2012, the rate of potentially avoidable hospitalizations for Medicaid enrollees for

chronic conditions in New York City was higher than the statewide average.[vi] In the near future, the primary care shortage is projected to worsen due to overall population growth and aging as well as the expansion of health insurance coverage.[vii]

A 2013 report by CHCANYS, with support from the New York State Health Foundation, analyzed FQHC capacity in various geographic areas and the potential sustainability of capacity expansions to sort New York City neighborhoods into three tiers, ranked in order of priority areas in terms of FQHC need and sustainability.[viii] Tier one included sixteen neighborhoods found to have both the highest need for expanded access to primary care and the highest rate of sustainability, based on such factors as number of primary care doctors, percentage eligible for but not enrolled in publicly-funded health insurance, and percentage of population not covered by FQHCs. This report, entitled *The Plan for Expanding Sustainable Community Health Centers in New York,* formed the basis of Mayor de Blasio's pledge to create at least 16 community health center sites in tier one neighborhoods in NYC during his term as Mayor.

We are therefore very pleased to see that Mayor de Blasio included $16.5 million for health center expansion in his preliminary budget. This funding would provide working and capital grants to facilitate the development and expansion of at least ten high-performing, community based primary care health centers in the underserved, high need New York City communities identified as priority areas in the aforementioned report. We urge you to support the Mayor's investment in health center expansion.

Because FQHCs are embedded in and reflective of their communities, they have a history of being nimble and able to respond quickly to their communities' changing health care needs. Despite this, FQHCs tend to have less direct access to funding – and capital funding is the most difficult to access, though the most critical for increasing capacity to serve additional patients. All Affordable Care Act (ACA) capital and operating dollars available to FQHCs have been expended and additional operational funding opportunities are set to expire in 2015. [ix] Other funding streams, such as the highly competitive federal New Access Point grants, are primarily

operational and only a small percentage may be used for capital projects. Furthermore, while Governor Andrew Cuomo's 2015 budget proposed $1.4 billion in capital funding for hospital development and restructuring, there is no clear investment in community based providers, including FQHCs. Providing City resources for FQHC expansion would ensure that primary care in underserved neighborhoods is delivered by qualified providers who focus on integrated, comprehensive care and have deep roots in and an understanding of the communities they serve.

Funding primary care expansion in New York City is also well aligned with state and federal healthcare delivery transformation initiatives, including New York's Delivery System Reform Incentive Payment (DSRIP) Program, which aims to reduce avoidable hospital admissions by 25% over five years. As safety net primary care providers, FQHCs are integral to the success of the DSRIP Program and have been working closely with Performing Provider Systems (PPS) in all regions throughout the City and State to design and implement transformative projects to support the program's goals. We agree that focusing on reducing hospitalizations and strengthening community-based care models in the primary and behavioral health care sector is essential.

In order to fulfill DSRIP's laudable goal of system transformation and reduction in avoidable hospitalizations, there is a need to build a larger system of FQHCs and other community-based healthcare providers in many neighborhoods in the City. FQHCs are the backbone of access to care in many communities because they are heavily relied upon by the uninsured, underinsured, and publicly insured—the very population that tends to over utilize hospitals. This expansion requires access to affordable capital that enables community-based primary care providers to build or expand facilities in targeted neighborhoods, which will be essential to achieving true delivery system transformation.

While the $16.5 million for primary care expansion in the Mayor's preliminary budget is an important first step toward expanded primary care services, this funding will likely only cover a small portion of the costs associated with health center expansion. While costs can vary widely, a rough estimate of capital costs for developing an FQHC facility is approximately $477 per

square foot, or $7.6 million for a 16,000 square foot facility to provide 10,000 patients an average of 3.5 visits per patient per year.[x] Constructing ten health centers of this size, or the equivalent, would be estimated to cost $76 million. These figures include average site acquisition costs, which are highly variable.

Due to the high cost of health center expansion, it will be critical that providers leverage additional outside resources, such as FQHC equity, NYS and federal programs, New Market Tax Credits, nonprofit and private lenders, foundations, and other sources. We understand that the City plans to develop a loan guarantee program to compliment the proposed $16.5 million in grants, which will be a necessary component of a successful expansion project. We look forward to working with the City Council and the Mayor's Office to ensure the success of this initiative.

I am happy to answer any questions you may have.

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[i] A federally designated Health Professional Shortage Area (HPSA) is "(1) An urban or rural area (which need not conform to the geographic boundaries of a political subdivision and which is a rational area for the delivery of health services); (2) a population group; or (3) a public or nonprofit private medical facility." U.S. Department of Health and Human Services. http://bhpr.hrsa.gov/shortage/hpsas/designationcriteria/designationcriteria.html

[ii] Brooklyn Health Systems Redesign Work Group. "At the Brink of Transformation: Restructuring the Healthcare Delivery System in Brooklyn." November 28, 2011. https://www.health.ny.gov/health_care/medicaid/redesign/docs/brooklyn_mrt_final_report.pdf

[iii] Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services. "Reducing Nonurgent Use of Emergency Departments and Improving Appropriate Care in Appropriate Settings." Federal Policy Guidance, CMS Informational Bulletin. Jan. 16, 2014. http://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-01-16-14.pdf

[iv] https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/performance_data/docs/chartbook1_avoidable_hospitalization_new_york_city.pdf

[v] Reviewing 20 years of research from over 100 studies in high-performing clinical settings, the American College of Physicians provided evidence for the critical role of primary care in chronic disease management – at a lower cost – and the urgent need to prevent shortages in primary care access. American College of Physicians. "How Is a Shortage of Primary Care Physicians Affecting the Quality and Cost of Medical Care?" Philadelphia: American College of Physicians; 2008: White Paper. http://www.acponline.org/advocacy/current_policy_papers/assets/primary_shortage.pdf

[vi] Medicaid Institute at the United Hospital Fund, Medicaid Regional Data Compendium, November 16, 2014. http://www.uhfnyc.org/publications/881021

[vii] Petterson S., et al. Projecting US Primary Care Physician Workforce Needs: 2010-2025. Annals of Family Medicine. 2012 Nov-Dec; 10(6): 503-509

[viii] *The Plan for Expanding Sustainable Community Health Centers in New York* developed by CHCANYS and the NYS Health Foundation.

[ix] While ACA provided $11 billion to Section 330 of the Public Health Service Act, which grants funding to FQHCs, this mandatory funding authority is set to expire after September 30, 2015. From the Geiger Gibson Community Health Policy and RCHN Community Health Foundation Research Collaborative. Policy Research Brief No. 37: "How Medicaid Expansions and Future Community Health Center Funding Will Shape Capacity to Meet the Nation's Primary Care Needs: A 2014 Update" http://publichealth.gwu.edu/pdf/GGRCHN_PolicyResearchBrief_37.pdf .

[x] *The New York State Community Health Center Capital Grant Program Request for Grant Applications developed by PCDC.*

Communities for Healthy Food NYC

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West Harlem Group Assistance Submitted Testimony on Health Budget for Fiscal Year 2016
Hearing of the New York City Council Committee on Health

Submitted March 23, 2015

Thank you Chair Johnson, and Health Committee Members, for considering this testimony supporting Communities for Healthy Food's request for City Council Citywide Discretionary Funding in the amount of $760,000. My name is Deborah Pollock, Director of Social Services for West Harlem Group Assistance Inc. known as WHGA. I am submitting this written testimony on behalf of Communities for Healthy Food and West Harlem Group Assistance.

Communities for Healthy Food (CfHF) NYC is a new, innovative approach to expand access to affordable, healthy food in four of New York City's economically challenged communities. This place-based initiative integrates access to healthy and affordable food into every aspect of our comprehensive community development work – through resident outreach, nutrition education and cooking classes, creating new or improved healthy food outlets and generating food-sector jobs. A comprehensive evaluation of CfHF is underway with the NYC Food Policy Center at Hunter College.

This new initiative, seeded by $1.6 million from the Laurie M. Tisch Illumination Fund, addresses the interrelated issues of diet-related diseases, poverty, and unemployment to help residents live longer and healthier. CfHF taps LISC's value as an effective community development intermediary with strong neighborhood organization relationships, the ability to leverage capital and programmatic funds, and its track record as a facilitator, convener and technical assistance provider. CfHF builds on the existing work of LISC and its partners revitalizing struggling communities and improving overall quality of life.

Program Partners

- Cypress Hills LDC in Cypress Hills/East New York, Brooklyn.
- New Settlement Apartments in Mount Eden, Bronx.
- Northeast Brooklyn Housing Development Corporation in Bedford-Stuyvesant, Brooklyn.
- West Harlem Group Assistance in West Harlem.

These programs also reach some Queens neighborhoods.

These program partners are embedding healthy food strategies into community development work to:

1) Increase the availability of high quality, affordable, and nutritious foods;
2) Create new or improved healthy food outlets and venues;
3) Educate residents, housing staff, and community service providers about nutrition, healthy food preparation, and gardening;
4) Enable economic development opportunities through creating or expanding food-related jobs, improving existing or creating new healthy food venues and fostering urban markets and food related enterprises; and
5) Implement a comprehensive neighborhood outreach and awareness campaign.

West Harlem Group Assistance (WHGA) Accomplishments with an Impact on Health:

Here are examples of how WHGA' work with Communities for Healthy Food has affected health in West Harlem, the neighborhood where we build community:

- We have established a healthy food HUB in one of our formerly vacant commercial storefronts on Lenox Ave. In it we provide a range of healthy food and health-related resources:
    - A weekly client choice food pantry;
    - Co-located key services and programs like nutrition and culinary education, tax preparation services, Corbin Hill farm share distribution site, grocery store tours sign-up and meeting place;
    - SNAP (food stamp) referrals; and
    - Health screenings.

  I know I am preaching to the choir when I say that teaching nutrition and providing nutritious and healthy food is a key strategy for improving health.
- We also do general intake at the healthy food HUB and just began the Food Bank's TEN Program. That program ensures wrap around services for those using the food pantry. For example, if a person is using the food pantry, we explore what other needs they might have including mental health or domestic violence services and help with, under employment and unemployment. Pantry clients are either referred to a partner agency or we do the work ourselves at WHGA.
- We have a mental health program that has piloted the Communities for Healthy Food model for its 27 residents. The clients of our mental health program live in scattered site apartments and have healthy eating as a goal. They are in day treatment programs and have their own day at the client choice food pantry.
- WHGA also runs two homeless shelters; we have also incorporated the Communities for Healthy Food model into the shelter services and consuming healthy food is a goal. The shelters also have their own day at the client choice food pantry.

2014 Accomplishments for Communities for Healthy Food – 4 CDCs Combined:

- Provided more than 250,000 pounds of emergency food for close to 17,000 pantry clients.
- Started two new neighborhood farmers' markets and two farm share programs and created four new community produce gardens.
- Trained and employed 44 residents to become farm stand operators, farmers, and community chefs.

- Held CfHF program activities for close to 3,000 neighborhood residents. This includes: farm shares, youth programming, farmers market, gardening workshops and grocery store tours and cooking demonstrations.
- Hosted a variety of nutrition education and cooking classes for close to 500 neighborhood residents to increase: cooking skills to make healthy food on a limited budget; knowledge about what foods are healthier alternatives; and literacy skills to read nutrition labels.
- Equipped 500 neighborhood residents, CDC staff, and partner organizations with information about neighborhood healthy food resources and services and the importance of heathy eating, nutrition and gardening skills.
- Enrolled 600 families in public nutrition assistance programs, like the federal Supplemental Nutrition Assistance Program (SNAP), formally known as food stamps.
- Connected directly with close to 6,500 residents through neighborhood outreach campaigns to raise awareness of the importance of healthy eating, the availability of local healthy food resources, and help strengthen community networks.
- Converted four corner stores to healthy corner stores.

Impact of New City Council Funding

We respectfully request $760,000 in City Council funding which would allow CfHF to expand and reach more low-income families and give individuals the tools they need to create healthier lives and build demand for healthy food, so that nonprofits, community-based organizations, city departments, and funders can partner with NYC businesses and investors to provide a better infrastructure for healthy food in underserved neighborhoods.

Impacts across the Four Boroughs

- Provide 275,000 pounds of emergency food for 19,600 pantry clients.
- Sell over 40,000 pounds of local produce to in need residents at farmer's markets and farm shares that CfHF started in collaboration with local nonprofits. Residents can use food stamps and NYC Health Bucks for purchases.
- Enable economic development opportunities by:
    - Employing 34 local, neighborhood residents as farm stand operators, urban farmers, community gardeners, and community chefs; and
    - Equipping 15 residents to incubate food businesses.
- Host a variety of nutrition education, cooking classes, and cooking demonstrations for 750 neighborhood residents to increase: cooking skills to make healthy food on a limited budget; knowledge about what foods are healthier alternatives; and literacy skills to read nutrition labels.
- Equip over 300 neighborhood residents, CDC or partner organization staff with information about neighborhood healthy food resources and services, knowledge on the importance of heathy eating and nutrition, and gardening skills.
- Reach 2,500 community residents through a neighborhood outreach campaign designed to raise awareness of the importance of healthy eating, the availability of local healthy food resources, and help strengthen community networks.
- Support the conversion of 5 healthy food corner stores and their owners.
- Improve the nutrition and wellness environment at early childcare and school facilitates for 625 children.
- Enroll at least 450 families in public nutrition assistance programs, like the federal Supplemental Nutrition Assistance Program like (SNAP), formally known as food stamps.

About the Partners:

West Harlem Group Assistance (WHGA) - *West Harlem*
West Harlem Group Assistance, Inc. (WHGA), a community-based development corporation was established in 1971 to revitalize the under-invested West and Central Harlem communities riddled with dilapidated and abandoned buildings. Since 1971, WHGA has developed 1,037 units of affordable housing and owns 43,676 square feet of commercial space in West Harlem. WHGA owns and manages affordable housing and other commercial and community spaces; delivers an array of social and economic development programs and services; and has close ties to the neighborhood residents, allowing the organization to effectively infuse healthy food access programs and activities into their comprehensive community development work. In 2014, with the support of LISC NYC, WHGA redeveloped one of their vacant storefronts on Lenox Avenue now called the West Harlem Community Healthy Food Hub, serving as a portal to improve access to healthy food and advance educational prospects related to health and nutrition for seniors, youth, families, and adults.

Northeast Brooklyn Housing Development Corporation (NEBHDCo) - *Bedford-Stuyvesant, Brooklyn*
A leading affordable housing developer since 1985, NEBHDCo has developed and self-manages 929 residential units and 17 commercial units in 92 buildings in Central Brooklyn, and also provides tenant and community services. As one for four CDCs in LISC NYC's Communities for Healthy Food initiative, NEBHDCo owns and manages affordable housing and other commercial and community spaces; delivers an array of social and economic development programs and services; and has close ties to the neighborhood residents served, including seniors, youth, families, and adults. NEBHDCo also works with many local partners on a multi-faceted community healthy food access program, allowing them to effectively implement healthy food interventions into locally-owned assets through their comprehensive community development work.

Cypress Hills Local Development Corporation (CHLDC) - *Cypress Hills, Brooklyn*
With community residents leading the way, the mission of Cypress Hills Local Development Corporation is to build a strong, sustainable Cypress Hills and East New York, where residents achieve educational and economic success, secure healthy and affordable housing and develop leadership skills to transform their lives and community. We serve over 9,000 local residents each year, many of whom are immigrants, through affordable housing development, sustainability planning, housing counseling, community organizing, college access and persistence programs, career and education programs, and youth and family services. CHLDC is working with LISC NYC to increase access to healthy food for seniors, youth, families, and adults through comprehensive community development work. CHLDC owns and manages affordable housing and other commercial and community spaces; delivers an array of social and economic development programs and services; and has close ties to the neighborhood residents. CHLDC's strategic interventions, integrated into existing programming and locally-owned assets, are designed to strengthen the local food system and reconnect community members with all aspects of it – from garden to table, including hands-on workshops about growing food at community gardens; nutrition, health, and effective food budgeting educational sessions; expansion of Cypress Hills' youth market with onsite cooking workshops; and health screenings at a senior center, affordable housing buildings, and local schools. CHLDC is working with the Cypress Hills Child Care Corporation, serving approximately 500 children and their families, to increase healthy food options served at their early childhood facilities and engage parents in meal improvements. Lastly, Cypress Hills is working with local bodegas and restaurants to increase healthy offerings, and help increase community demand.

New Settlement Apartments (NSA) - *Mount Eden, the Bronx*
New Settlement Apartments is a community development organization based in the Mt. Eden community of the Southwest Bronx, with a 25-year demonstrated commitment to increasing preparedness and access to high-quality public and post-secondary education, safe and affordable housing, fair and sustainable employment, and expanding opportunities for healthy and active living for youth, seniors, adults, and families. New Settlement has provided 1,022 affordable homes in 17 multi-family buildings and collaborates with community residents and develops partnerships to create services and opportunities that celebrate the inherent dignity and potential of individuals and families. NSA owns and manages affordable housing and other commercial and community spaces; delivers an array of social and economic development programs and services; and has close ties to the neighborhood residents allowing them to effectively implement healthy food access programs and activities into their comprehensive community development work. New Settlement Apartments and LISC NYC are partnering to reshape the neighborhood food landscape, with a focus on youth and families, by concurrently improving access to affordable healthy food and embedding interactive food education and nutrition promotion within New Settlement's programing and assets.

Local Initiatives Support Corporation (LISC) – New York City
LISC NYC's mission is to help resident-focused, community-based development organizations transform distressed communities and neighborhoods into healthy places to live, do business, work, and raise families. Over the last 34 years, LISC New York has invested approximately $2.3 billion in more than 75 New York City community development corporations and other local, nonprofit organizations. With our support, these organizations have developed over 34,600 affordable homes and more than 2.3 million sq. ft. of community and commercial space. For CfHF, LISC NYC is providing technical assistance and program management support; leveraging government and private funding; organizing trainings; creating cross-sector partnerships; completing a comprehensive program evaluation with the NYC Food Policy Center; and documenting the program model through neighborhood stories and media outlets.

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New York City Alliance Against Sexual Assault

Good afternoon and thank you, Council Member Corey Johnson, Chair of the Health Committee for allowing me to submit testimony on behalf of the New York City Sexual Assault Initiative. My name is Mary Haviland and I am the Executive Director of the New York City Alliance Against Sexual Assault. Founded in 2000, our mission is to prevent sexual violence and reduce the harm it causes through prevention and intervention.

Sexual assault is a serious public health and public safety issue in our community. Despite continued efforts from the community and increased visibility in media, sexual violence remains a pervasive issue. New York City has experienced a five-year upward trend in forcible rapes, with a total of **1,537 rapes reported to the NYPD in 2014**. The forcible rapes reported in 2013 represents nearly **65% of the total number of reported rapes in New York State.** Moreover, using the CDC National Intimate Partner and Sexual Violence Survey (NISVS) prevalence figures, New York City has almost 840,000 women and men who have experienced rape in their lifetimes, about 2.72 million who have experienced other rape victimization in their lifetimes, and 47,220 women who have experienced rape in the last 12 months.

I am here today to talk about the Sexual Assault Initiative which is comprised of four of the city's leading service providers including **Kingsbridge Heights Community Center, Mount Sinai's Sexual Assault and Violence Intervention (SAVI), the New York City**

Alliance Against Sexual Assault, and Mount Sinai St. Luke's-Roosevelt Crime Victims Treatment Center (CVTC). Collectively the Initiative provides free and comprehensive services to **over 2,000 victims of sexual assault**, including **children, women, and men**, and conducts over **10,000 counseling and training session** across the five boroughs.

The New York City Sexual Assault Initiative respectfully requests funding in a total of $600,000 – $150,000 for each of the four programs in FY2016. Demand for services rises and shifts each year. Our request is to address the **current waitlists of all groups** as well as to **effectively respond to the increased demand for services and training from colleges and universities.** For instance, the Alliance in partnership with Kings County District Attorney's Office trained 90 professionals from CUNY including Title IX Coordinators as well as related personnel. However, with the limited staff and resources the Initiative is unable to effectively respond to all victims who are calling for assistance or to the current training requests that are coming to our programs from college campuses. We believe that no sexual assault victim should have to wait to receive services. With the proposed funding amount of $600,000, the Sexual Assault Initiative seeks to:

- Hire a Mandarin-speaking Master's level trauma therapist to meet the needs of the growing population of Mandarin-speaking trafficking survivors in Queens at **Mount Sinai's Sexual Assault and Violence Intervention (SAVI)**
- Hire a Spanish-speaking trauma counselor with experience working with male victims, and intimate partner violence in Manhattan at **Mount Sinai St. Luke's-Roosevelt Crime Victims Treatment Center (CVTC).**
- Hire a bilingual Spanish-speaking Master's level trauma therapist to provide individual therapy sessions to children and families in Bronx at **Kingsbridge Heights Community Center**;

- Respond to the increased need for training and certification of emergency room professionals treating sexual assault victims in all five boroughs at the **New York City Alliance Against Sexual Assault**; and
- For each of our programs to respond to the increased demand for services and training from colleges and universities to help better handle sexual assault cases in all five boroughs.

I would like to add a few more words about the Sexual Assault initiative and the role of the Alliance in that initiative. The Alliance has been in the leadership of the Initiative over the last 3 yours and we would like to acknowledge that the Council generously increased the initiative by 50% last year from $200,000 to 300,000. This has allowed our council-funded, Sexual Assault Forensic Training Institute to be that much more effective in the last year. For the Alliance's part, we have been able to train 90 medical professionals so far this year, and individually certify 59 of those as Sexual Assault Forensic Examiners (26 applications are pending). We have also been able to bring a new Center of Excellence on line, the Lenox Hill Health Plex, located on 7th Ave. and 13th St. in Manhattan. A Center of Excellence is willing to provide best practice acute care to survivors of sexual assault through its emergency department. The Alliance facilitated this certification process through the NYS Department of Health, adding the first new Center since 2011, bringing the total in NYC to 18. In addition, the Alliance has training 190 human services workers including 90 CUNY title IX, safety and student affairs staff in trauma centered approaches to survivors of sexual assault. This is a snap shot of what just one of us in the Sexual Assault Initiative was able to do in the last 8 months as a result of City Council funding.

At this time, I would like to turn your attention to the state funding crisis. Rape Crisis Network statewide has been destabilized by the state funding cut in a total of over $4million. As the network faces the largest staff layoff in its history, 15 rape crisis programs in New York City

are also immediately affected. The Alliance on behalf of the rape crisis program network, are proposing a three-part initiative to further address the urgent needs faced by the network that serves thousands of victims and survivors annually. The network asks the following support:

- Provide grants of **$50,000 to 15 qualifying, certified rape crisis centers** that provide direct services to survivors of sexual assault.
- Create **2 SAFE Centers of Excellence** and **2 rape crisis services** in **Brooklyn and Bronx**, the boroughs with the most limited acute care services for victims of sexual violence.
- Create **on-campus technical assistance, back-up centers** to provide training and capacity building and **centralized call centers** that provide **crisis intervention counseling** and serve as **referral hubs** to **campuses, universities, and their students** in New York City.

More detailed information on this proposal is available from Mary Haviland, mhaviland@svfreenyc.org

On behalf of survivors of sexual assault, I thank you for your reading this testimony.

New York City Council

FY 2016 Preliminary Budget Hearing

Health Committee

Hon. Corey Johnson, Chair

March 23, 2015

Submitted on behalf of:

Anna C. Kril

Founder & President

Astoria/Queens SHAREing & CAREing, Inc.

(dba SHAREing & CAREing)

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On behalf of the thousands of cancer survivors and community members served each year by Astoria/Queens SHAREing & CAREing, Inc. (dba SHAREing & CAREing) I am here today to request that the Council allocate $250,000 in expense funding to SHAREing & CAREing in the FY 16 Budget. ***This funding is critical for SHAREing & CAREing's survival and will be used to 1) offset the loss of Cancer Initiative funding in the upcoming budget and 2) expand our highly successful and popular flagship education program, "Be A Friend to Your Mother" High School Outreach Program, to High Schools throughout Queens.***

Since 2009 (FY 10), SHAREing & CAREing has received funding under the Council's Cancer Initiative. This funding, approximately $128,125 yearly with the NYS Article 6 match, has been a blessing to our organization and has enabled us to continue to serve women and men with cancer in Queens and throughout the city. With the baselining of the Initiative in the FY 15 Budget, however, these funds will no longer be awarded (starting in FY 16) to community groups which provide direct and/or support services to breast cancer survivors and their families. Instead, this funding will be awarded via RFP to one organization for the purpose of implementing and monitoring a city-wide colorectal Cancer Prevention Navigation Program. ***The loss of this funding will significantly impact on our ability to assist cancer survivors and their families.***

Through the years, Council funding (Cancer Initiative and Member Discretionary) along with our own fundraising and foundation grants has allowed SHAREing & CAREing to provide free outreach, education, counseling, direct services and advocacy to women and men living with cancer, with an emphasis on medically underinsured and uninsured linguistically isolated, minority populations throughout the city. Through our telephone hotline, educational symposiums, cancer screenings and local office, we assist approximately **4,000 - 5,000** individuals a year, providing cancer awareness and education, linkages to free or low-cost cancer screenings and treatment, patient navigation, case management, family support services and wellness programs as well as assisting with insurance matters, transportation to and from treatments, chemotherapeutic drug coverage, surgical camisoles, mastectomy bras and prosthesis and wigs. And since our founding in 1994, my team and I have collaborated with local hospitals and physicians to coordinate free cancer screenings and health forums for women and men who otherwise would have little access to these services, referring over **5000** women to mammography screening.

21 years after our creation, the need for our services in continues especially in Queens. According to a recent survey commissioned by the Peoples Budget Coalition for Public Health, and conducted by the American Community Survey, 11% of Queens County's population at a MINIMUM is uninsured and at a maximum that number rises to 35% uninsured. Of the districts with the highest rates of uninsured, Council Districts 21 and 25 at

26-35% uninsured; Council Districts 20 and 26 at 21-25% uninsured; and Council Districts 22, 28 and 30 with 16-20% uninsured, SHAREing & CAREing has made inroads into these communities through our High School Outreach Programs, Community Health Forums and free cancer screenings, significantly raising awareness about the importance of early detection of breast, ovarian and other forms of cancer.

SHAREing & CAREing's High School Outreach Program was created in 1995 as an outgrowth of my own cancer experience. Under this program, SHAREing & CAREing educates high school students about health and wellness, breast, prostate and testicular cancer and the importance of monthly self-exams. The program also encourages young people to speak to the older women and men in their lives to urge them to get screened. SHAREing & CAREing then links these women and men to free or low cost cancer screenings and, if diagnosed, to treatment and other support services. This program, which falls within the NYS Learning Standards for Health and Physical Education, has been extremely well received by students and faculty alike. ***Since 1995, we have reached 29,000 students and approximately 5000 faculty members through these outreaches and have linked over 2700 women (the mothers, grandmothers and aunts of our high school students) to free breast cancer screenings, screenings they would not otherwise have received.***

It is my fervent belief, as well as that of SHAREing & CAREing's staff and Board, that educating our young people and engaging them in knowing and

caring for their bodies is a crucial and needed step in increasing health and wellness among our future generations and in assuring early diagnosis of cancer.

When I was diagnosed with cancer over two decades ago, I discovered that there was a real need for support and education services for women diagnosed with this disease. As a result I, along with three other survivors, established SHAREing & CAREing to address the needs of women living with breast and ovarian cancer. Through the years, we have expanded our mission to address the needs of women, and men, living with breast, ovarian, prostate, colon and other forms of cancer, although our largest population served are still women with breast cancer.

SHAREing & CAREing serves women and men of all ages, ethnicities, races and economic backgrounds citywide, with the majority of those served residing in Queens County. It is through this organization, and the efforts of its dedicated staff and volunteers, that thousands of cancer survivors and their families have learned to live with the diagnosis of cancer, receiving support, counseling, benefit and medical information, education, and hope. SHAREing & CAREing has helped these survivors discover their own inner strength to face their battle against cancer.

As a 21 year cancer survivor, I am not only blessed to still be alive but blessed to be part of an organization that not only educates and empowers but an organization that actively helps to save lives. Day in and

day out, cancer survivors, family members and community members contact our office seeking help, be it counseling, direct services, linkages to screening or treatment or just a shoulder to cry on and be comforted. My staff and I are always there for whoever calls or walks in our doors. No one is ever turned away.

On behalf of these women and men, and all the others we serve, I am asking for your help and leadership. ***Our situation is dire and your help is imperative so that we can continue our mission of providing direct services, as well as counseling, support AND hope, to those diagnosed with cancer.***

Thank you.

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Community Service Society | Fighting Poverty Strengthening New York

David R. Jones
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Steven L. Krause
Executive Vice President &
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Community Service Society of New York
Testimony before
New York City Council Committee on Health
Preliminary Budget Hearing

March 23, 2015

The Community Service Society of New York (CSS) respectfully submits this testimony for the Preliminary Budget Hearing of the Health Committee of the New York City Council.

CSS is a 170 year-old organization that seeks to address the root causes of economic disparity. Our mission is to promote policies that advance the economic security of low- and moderate-income New Yorkers by bringing their perspectives to the policy conversation. To this end, we work to expand access to affordable, quality health care for all New Yorkers, through advocacy and direct consumer assistance. CSS sponsors the State's largest Navigator program consisting of a network of 33 community-based organizations, Chambers of Commerce, and other business-serving groups. Together, we offer enrollment services in 61 out of New York's 62 counties. In addition, CSS and its partners—the Empire Justice Center, Medicare Rights Center and The Legal Aid Society—administer Community Health Advocates (CHA), an all-payor health care consumer assistance program, which helps New Yorkers understand and use their health insurance and, if uninsured, access low-cost services.

In this testimony, CSS urges the City Council to cement the successful implementation of the Affordable Care Act by: (1) funding post-enrollment consumer assistance services at CSS's toll-free helpline through the Access Health NYC collaborative, and (2) restoring funding to a network of community-based organizations through the program formerly known as NYC MCCAP (NYC Managed Care Consumer Assistance Program) but now called CHA.

The ACA works no place better than in New York, which has implemented arguably the finest health insurance shopping website, or Marketplace, in the country. An eye-popping 2.1 million New Yorkers signed up for health insurance by the end of the second open enrollment period which began on November 15, 2014 and ended on February 15, 2015.

1. **Fund Post-enrollment Consumer Assistance Helpline through Access Health NYC**

Getting 2.1 million New Yorkers insured is an important first step. But ensuring that consumers actually use their new coverage to access care is to attain the ultimate goal of having healthy NYC communities.

From the perspective of a newly insured consumer, the health insurance system remains complicated. Eighty-eight percent of Marketplace enrollees reported that they were uninsured at the time of enrollment, both the newly covered as well as those who have been covered for years, reported needing help with post-enrollment issues. A recent Kaiser Family Foundation survey of more than 800 Navigator/Assistor programs found that 90% reported that enrollees returned for additional post-enrollment, insurance assistance. See, Kaiser Family Foundation, *Survey of Health Insurance Marketplace Assistor Programs*, July 2014.[1] Navigators corroborate that they see high numbers of returning clients who, after successfully enrolling, seek additional help with issues such as finding in-network providers, requesting plan cards, resolving billing issues, or understanding communications from their plans. Consumers with no previous health coverage experience are also likely to need help navigating their coverage upon enrollment. Consumers need help understanding insurance concepts like deductibles, co-payments, co-insurance, and maximum out-of-pocket costs, following complex processes to resolve insurance disputes, filing complaints, and appealing plan decisions.

In 2010, New York State designated Community Health Advocates as New York's Independent Consumer Assistance Program.[2] Services provided by CHA are unique and are not redundant of the services provided by Navigators. CHA is an all-payor model which provides one-stop shopping for consumers who can access ombudsprogram services through a central helpline or at one of the 21 community based organizations (CBOs) operating in neighborhoods where consumers live and work. The CHA program has been lauded nationally as the leading model of a consumer assistance program by the Kaiser Family Foundation, the National Governor's Association, Families USA, and HHS. To date CHA has:

- Brought financial resources, training and technical assistance to 21 community-based organizations, small business serving groups and chambers of commerce across New York State to provide direct services in localities.
- Established a live answer, multilingual, toll-free helpline that handles 10,000 calls per year. The CHA helpline is an important alternative for New Yorkers with schedules that do not permit them to accommodate time for in-person services.
- Assisted over 200,000 New Yorkers since October 2010.
- Saved approximately $14 million for New Yorkers since 2010.

[1] Available at: http://kff.org/health-reform/report/survey-of-health-insurance-marketplace-assister-programs/.
[2] ACA § 1002.

- Provided a one-stop-shop for consumers with all types of health insurance and for the uninsured.[3]
- Offered real-time feedback for policy makers. CHA serves as the eyes and ears for policy makers as health care reform is implemented and works closely with New York's state and city agencies.

CHA was originally a New York City-funded program called the Managed Care Consumer Assistance Program (NYC MCCAP) that operated between 1998 and 2010. MCCAP was funded by the City Council, which allocated $2 million for the program and leveraged these resources with federal Medicaid matching funds for a total program funding of $4 million. With this funding, CSS and its specialists partners trained and provided technical support to a network of 26 CBOs to provide direct assistance to health care consumers in over 10 languages across diverse communities in New York City. After more than a decade of building capacity in CBOs, and serving almost 150,000 New York City residents, NYC MCCAP had to be dismantled when the City Council funding was eliminated for Fiscal Year 2011.

The defunding of NYC MCCAP coincided with the availability of ACA funds for CAPs. Consumers throughout the state benefited from NYC MCCAPs infrastructure and expertise by transforming NYC MCCAP into a state-wide program under the name of CHA. In 2010, CHA's initial funding was through a grant to New York State by the U.S. Department of Health and Human Services through a state legislature-sanctioned "dry appropriation" in the amount of $2.3 million.

CSS was able to incorporate just a few of the former NYC MCCAP agencies. Accordingly, New York City receives fewer resources because the funding had to be distributed across the entire state. While 61% of NYC MCCAP clients were from racial and ethnic minorities, that number came down under CHA to 43%. While 70% of NYC MCCAP services were provided in languages other than English, only 25% of CHA services have been provided in other languages. The transition of CHA from a city network to a statewide network has brought valuable services to upstate communities that needed them dearly, but New York City lost important resources for its underserved communities.

At it's height in 2013, CHA administered $5.7 million in grant funding to a network of 30 community based organizations, and 34 chambers of commerce and other small business-serving groups and supported a toll-free, live answer helpline. Thanks to the incredible success of the NY State of Heath Marketplace, the number of insured New Yorkers has grown exponentially.

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[3] While consumers routinely call DOH, the Department of Financial Services (DFS) and the Attorney General's office regarding their health plans, CHA is the only entity that offers one-stop assistance for health care consumers regardless of their source of coverage.

As a result, the need for CHA's post-enrollment services is now more critical than ever. CHA funding is due to expire in June 2015, absent state legislative action.

Recommendations:

(1) Fund Access Health NYC's request for $5.5 million. Under this initiative the CHA Helpline would receive funding to provide post-enrollment assistance services over the phone and to support community based groups and City Council constituents.

(2) New York City should restore $2 million funding for CHA (formerly NYC MCCAP) and leverage the infrastructure and expertise that CHA has developed for several years to ensure that consumers who receive services from Navigators have somewhere to go for help with their post-enrollment needs. City funding for CHA is necessary to recover the linguistic diversity that the network once had, and to ensure that these needed services are available to communities of color. Funding for CHA will also support consumer assistance services for people transitioning out of the marketplace–like those who become eligible for Medicare and to those who are not eligible to obtain coverage through the New York State of Health and need assistance accessing low cost services and hospital financial assistance. Based on our experience, a $2 million fund is potentially eligible for $2 million in Medicaid matching funds.

Thank you for the opportunity to present testimony before this Committee.

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The New York Immigration Coalition
Testimony on NYC FY 2016 Budget

Claudia Calhoon, MPH

March 23, 2015

Good Afternoon, my name is Claudia Calhoon, and I am the Health Advocacy Senior Specialist at the New York Immigration Coalition. I'm here today to urge the Council to include **$5.5 million** for an important new initiative called Access Health NYC in the FY 2016 budget. Access Health NYC is a key priority of the People's Budget Coalition for Public Health and represents an intensive collaboration of the five lead organizations: Coalition for Asian American Children and Families, Commission on the Public's Health System, Community Service Society, Federation of Protestant Welfare Agencies, and the New York Immigration Coalition.

I'd like to start by thanking the Chair and members of the New York City Council Committee on Health, Councilmember Corey Johnson, and City Council Speaker Melissa Mark-Viverito for their extraordinary commitment to making sure all New Yorkers can access the health services they need.

The NYIC is an advocacy and policy umbrella organization for more than 150 multi-ethnic, multi-racial, and multi-sector groups across the state working with immigrants and refugees. Our members serve communities that speak more than 65 languages and dialects. The NYIC Health Collaborative brings together-immigrant serving organizations from the frontlines of the battle to improve health access. We hear stories from our members on a daily basis about the urgent need for funding for immigrant groups to conduct outreach and education about health access in their communities.

Access Health NYC is a city-wide proposed funding initiative to support new education and outreach efforts on health care coverage and services for all New Yorkers. $5.5 million will support lead agencies to fund, train, monitor/evaluate, and provide technical assistance/ guidance to local CBO's as well as support a consumer helpline. Access Health NYC will serve two important functions: it will improve health access by linking individuals who are eligible for Affordable Care Act (ACA) coverage to enrollment and post-enrollment services; and will link those who cannot participate in ACA coverage to existing safety net health care such as HHC and Federally-qualified Health Center facilities.

Enrollment for eligible populations

As part of ACA implementation, New York State awarded federal funds to networks of community-based organizations statewide to serve as "Navigators" to assist with applications for health insurance plans offered on New York State of Health, the state's ACA marketplace. Many of these organizations are here today and have been pivotal in linking eligible immigrants to coverage. But the state did not provide support for public education and outreach. We are asking the city to fill this gap in order to address several key barriers that keep eligible populations from taking advantage of existing programs:

- Language access is one key challenge. 23% of New York City's population over the age of 5 are limited English proficient, meaning that they need interpretation or translation in

order to communicate effectively. A little over half of that population speaks Spanish; the other half speak nearly 150 other languages and dialects.[i] Health Collaborative members like POMOC, which has been serving the Polish-speaking community for more than 30 years, inform us that language access keeps eligible members of their community from signing up for coverage.

- A second set of barriers relates to fears about using health insurance. Unfounded fear of immigration consequences of accessing and using health care services continue to discourage immigrants. During a time of stalled immigration reform and record deportations, it is not surprising that immigrants have been hesitant to access government services and programs. Immigrants need to hear that they can safely apply for benefits for themselves and for their families and that using public health insurance such as Medicaid will not have immigration consequences. Specifically, young people eligible for Deferred Action for Childhood Arrivals (DACA) need to know that they are eligible for Medicaid if they meet the income requirements. And although President Obama's Executive Order is currently delayed by an injunction, once it is lifted and the DACA expansion and implementation of Deferred Action for Parents of American Citizens and Lawful Permanent Residents (DAPA) moves forward, it will be important for all New York City-based applicants to know that they may be entitled to Medicaid.
- Related to those concerns, are the challenges of navigating the system for mixed immigration status families. Many families in New York are in this situation, meaning that some members are undocumented while others are US citizens or otherwise lawfully present. Within a particular household, different family members can be eligible for distinct benefits.

The need for post-enrollment services

We also hear from Collaborative members that even after eligible individuals are enrolled in coverage, they continue to need what we call "post-enrollment" assistance. As we all know, insurance can be confusing for those of us who have a fair amount of sophistication with the health system. Questions about what to do with insurance once you have it, and how to get the best out of the health system can be very challenging for immigrants, especially those who are low-English proficient. Many immigrants who recently signed up have insurance for the first time. Tasks like getting prior authorization, appealing denials, and resolving billing disputes are especially tough for populations that are new to health insurance. Part of our $5.5 million request is to support the Community Health Advocates (CHA) Helpline to assist consumers with using their coverage. Incorporating helpline services will strengthen Access Health NYC's ability to help immigrant communities across the range of eligibility and enrollment categories, providing seamless resource for all immigrants in finding and using the healthcare system.

Services for those who are not eligible for coverage

Despite the fact that undocumented immigrants are not eligible for most forms of public coverage, they still have a range of options for services in New York City. Individuals can get very affordable care at HHC facilities through HHC Options, HHC's fee-scaled, charity care program. They can get heavily discounted care in their community at Federally Qualified Health Care Centers. Undocumented immigrants can get coverage for certain emergency and life threatening conditions by pre-certifying for Emergency Medicaid through the New York State of Health Marketplace. All children up to age 18 can get Child Health Plus and all pregnant women regardless of status are eligible for Medicaid, also through the Marketplace. But, for all the reasons I noted above, many undocumented immigrants are unaware that these programs exist, or are afraid to use them. Access Health NYC will educate immigrants about their options for

accessing care, and ensure that immigration status does not prevent any New Yorker from accessing the medical care they need.

Why CBOs need support for this work

One of the key elements of the Access Health NYC campaign is that CBOs are the key to addressing these challenges. CBOs of all sorts (both navigators and not) are being called upon to do this work whether they have funding or not. They are already fielding questions about health insurance, and being asked to translate documents, and called upon for help from individuals looking for services and information. CBOs need resources to be able to meet these demands from their communities. Unfortunately, immigrant-serving CBOs are often underfunded. They don't have the financial flexibility or the capacity to perform these tasks without support. CBOs are trusted by the community and are the best equipped to get the word out to individuals and families that they serve.

For instance, the Academy of Medical and Public Health Services serves a large Latino and Asian immigrant population in Sunset Park, Brooklyn and provides free health screenings and referrals to the community. They report that the majority of individuals don't know what resources are available to them, and that many are afraid to even ask. They recently told me about Brooklyn resident who spoke only Spanish who had severe abdominal pain related to an old hernia operation who didn't want to go to the doctor because he didn't think he could afford it. AMPHS was able to link him to a health care facility with sliding scale fees. Without the Academy of Medical and Public Health Services to let him know about available services, he would not have been able to see a doctor.

Another Health Collaborative member is the South Asian Council for Social Services, an organization that works in Queens to address the social service needs of the underserved South Asian and Indo-Caribbean communities. Last fall they worked with woman who speaks a rare South Asian language and was in immediate need of mental health services. Before they found SACSS, the family was unable find a therapist/counselor who spoke the same language or an interpreter. Through their contacts in the community, SACSS was able to connect the family to a counselor who spoke her language. This family had been desperate, and without SACSS' specific knowledge of service providers in this rare language, this woman would still be in need of mental health services.

In conclusion, I'd like to highlight our belief that New York City offers a rich network of resources for coverage and access. But they only are helpful to people if they know about them. Access Health NYC will help immigrants understand what their rights are and for what programs they qualify. For this reason, the NYIC is advocating for $5.5 million for Access Health NYC from the City Council. Our vision is that close to 80% of the funds be re-granted to CBO's to conduct 10 provider training events each and support 30 targeted education and outreach events throughout the city and to provide consumer assistance to New York City residents. We look forward to working with the City Council to create mechanisms to improve outreach and education about health coverage and access

Thank you.

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[i] Source: U.S. Census Bureau, 2011 American Community Survey http://factfinder2.census.gov/faces/tableservices/j

N Y L P I

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Testimony of
ERIN GEORGE,
NEW YORK LAWYERS FOR THE PUBLIC INTEREST
In Support of
Access Health NYC
March 23, 2015

New York Lawyers for the Public Interest (NYLPI) thanks the members of the Health Committee for the opportunity to submit testimony in support of preserving and expanding our city's public health programs and services through the allocation of funding for the Access Health NYC initiative. NYLPI's Health Justice Program is a member of the People's Budget Committee and has a long history of partnering with immigrant communities and communities of color to overcome the many systemic and institutional barriers to accessing quality health care.

Accessing healthcare in New York is complicated. Particularly for low-income communities of color. Many individuals are not aware of the various sources of free and low-cost care available, nor of the rights that they have when accessing healthcare. One consistent issue that arises in the communities that NYLPI serves is that individuals who fall into the category of PRUCOL status (Permanent Resident Under Color of Law) are not aware of their eligibility for full Medicaid. For seriously ill individuals, full Medicaid has huge benefits. It can mean the difference between a lifetime of twice-weekly dialysis and a kidney transplant.

Underserved communities frequently seek community based organizations (CBOs) for accurate and culturally competent information about public health programs and services. However, these CBOs are in great need of funding, support and training in order to ensure that every New Yorker understands how to access health care coverage and services.

Access Health NYC is a city-wide proposal that will fund CBOs to provide education, outreach and assistance to all New Yorkers regarding how to access health care and health coverage. Approximately 20% of Access Health NYC funds will go to lead advocacy agencies to support them in training, monitoring/evaluating and providing technical assistance to consumer CBOs. Close to 80% of the $5.5 million in funding will be re-granted to CBOs to conduct provider training events, outreach and targeted education throughout the city in order to provide consumer assistance to NYC residents.

The allocation of sub-grants will be based upon the number of uninsured/newly insured served and barriers to culturally and linguistically competent care in a CBO's geographical location. Implementation of Access Health NYC will result in better access to insurance coverage and primary and preventive care, reducing health care costs for families and safety net providers like HHC. More importantly, it will improve health outcomes for *all New Yorkers,* particularly those experiencing gaps in services.

For these reasons, New York Lawyers for the Public Interest urges City Council to direct the requested $5.5 million to fund Access Health NYC.

Independence care system

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Testimony of Marilyn E. Saviola, Senior Vice President, Women's Health Access Program
Independence Care System
Submitted to the Health Committee of the New York City Health Council
In Reference to FY2016 Preliminary Budget
March 23, 2015

In 2000, Independence Care System (ICS) opened its doors as New York's only Medicaid Managed Long Term Care plan specifically designed for people with physical disabilities. ICS currently provides services to New Yorkers covered under both the Medicaid and Medicare programs. Our mission is to support people with physical disabilities and chronic illness to live in their own homes and participate fully in their communities. This is accomplished through a model of disability competent care and coordination of the full range of long term care services including home care, health care, social services, and medical care.

ICS is a well-established, highly regarded, not-for-profit organization that serves over 5000 Bronx, Brooklyn, Queens and Manhattan residents. Through our work we have developed a deep understanding of the needs that are unique to people with physical disabilities, as well as extensive expertise in identifying and addressing glaring gaps in care.

The US Centers for Disease Control has confirmed that women with physical disabilities are a medically underserved population. Yet the healthcare system has done little to address the health disparities experienced by people with physical disabilities or the public health consequences of those disparities, when compared to what has been done to address disparities experienced by other minority groups.

As defined by the Americans with Disabilities Act, a disability is a physical or mental impairment that substantially limits one or more life activities. In the United States, an estimated 32,884,621 people have a disability, or 11.7% of the population. In New York City, approximately 11% of the population has a physical disability (889,210 people), with the Bronx having the highest percentage, 13.7%. Despite these numbers, and despite the 25 years that have passed since passage of the Americans with Disabilities Act, and the strong local and state civil rights laws on the books, people with disabilities continue to face enormous barriers to medical care.

While access to care is typically thought of in terms of lack of health insurance or distance to the closest provider, for people with physical disabilities the meaning is very different. For people

with physical disabilities, access to care is also defined by the physical infrastructure of a medical facility, the equipment that is or is not available, and the perception and attitudes of providers—among other factors. Ubiquitous barriers that impede access to basic medical care include: building ramps that are nonexistent; doorways that are too narrow; bathrooms, dressing rooms and exam rooms that are too small; exam tables that don't raise or lower; and the absence of accessible weight scales or transfer lifts.

In order to begin addressing these issues, in 2008 ICS launched what has become an award-winning Health Access Program for Women with Physical Disabilities to receive their annual cancer screenings and on-going OB/GYN care in designated facilities that are physically accessible and have staff who have been trained in disability sensitivity and awareness and clinical competencies. A nurse who is disability competent accompanies each of the patients to their appointments and provides assistance in transferring and positioning during their visits. HHC has implemented the Women's Health Access Program in two of its facilities and is in the process of expanding into three additional facilities over the next two years.

HHC and ICS have established a model of accessible care that is expanding to offer primary and preventative care to New Yorkers with disabilities. This is important because, as the National Institutes of Health Office of Disease Prevention and Health Promotion has established, people with disabilities regularly experience difficulties and delays in receiving routine medical care. For New Yorkers with physical disabilities, the ongoing lack of preventative and primary care is a major public health concern.

For many people with disabilities, their only regular contact with a doctor may be with a specialist related to their disability. For example someone with Multiple Sclerosis may see a neurologist who cares for their MS-related needs but does not conduct routine physicals, screen for heart disease, high blood pressure, diabetes, or other common conditions, or offer preventative services such as an annual flu shot.

In 2013, based on our advocacy efforts, the New York State Department of Health convened a work group chaired by then Deputy Executive Commissioner Sue Kelly and issued a "Dear Administrator" letter, instructing hospitals and health care facilities across New York State of their legal obligation to comply with all federal, state and local accessibility laws. Concurrently, in response to the report "Breaking Down Barriers, Breaking the Silence: Making Health Care Accessible for Women with Disabilities," coauthored by ICS and New York Lawyers for the Public Interest, the New York City Council held an oversight hearing sponsored by four council committees and chaired by then Health Committee Chair Maria Del Carmen Arroyo.

HHC was the only health care facility that responded to address the health disparities routinely experienced by women with physical disabilities. The City Council hearing opened the doors for ICS to meet with high level staff at HHC to discuss the inaccessibility of care and the requirement to become compliant with applicable laws. HHC then requested City Council funding and, as a result, the Council committed $2.5 million per year for two years to HHC to

make capital improvements to the women's healthcare areas of select facilities in order to make them more accessible for women with physical disabilities.

ICS partnered with HHC on this initiative, conducting environmental assessments of the selected facilities and making recommendations for renovations to increase accessibility. The money allocated in year one (FY 2014) is currently being used to purchase accessible equipment and make renovations to exam rooms and bathrooms in the women's health areas at four facilities. Unfortunately, the money was eliminated from the FY 2015 capital budget, preventing identified HHC facilities from obtaining the environmental assessments, trainings, and renovations that are desperately needed.

In the past year, via a joint grant, ICS has facilitated in-person disability sensitivity and awareness training in eight HHC facilities to 280 women's healthcare and radiology professionals. We have created a video for HHC to use as an annual training for its employees, and published a train-the-trainer manual to be used to spread the training even further.

ICS's work providing disability competency training to complement HHC's capital improvement project is a very small step toward increasing access to care for people with physical disabilities. Our objective, given the physical environment that exists today, is to enable and support hospitals and diagnostic and treatment centers in the short term to make their facilities safe and usable for a person with a physical disability. While our environmental assessments and trainings will not bring a facility to full compliance overnight, they are a critical step in enabling women with physical disabilities to receive lifesaving screenings and care.

In order to continue this work, it is imperative that the City Council restore funding in the amount of $2.5 million to HHC to complete the second phase of capital improvements to increase accessibility in the women's health areas of select HHC facilities, and help to expedite and continue this process until all HHC facilities are compliant.

Further, ICS will be submitting a request for funding to continue providing HHC with in-person disability sensitivity and awareness and clinical competency training for healthcare staff in additional facilities and to conduct environmental assessments of the women's health areas in facilities that may receive capital funding.

Respectfully submitted by:
Marilyn E. Saviola
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Testimony of Alex Leung, MPA/PA-C/MLI, Shop Steward for Medico-Legal Investigators at the OCME before the NYC Council Health Committee

March 23, 2015

Dear Chairman Johnson and members of the Health Committee,

It was a pleasure to meet your acquaintance and a rewarding opportunity to provide testimony informing you of the sorely understaffed Medicolegal Investigators at OCME that function in the very critical positions of the NYC medical examiner's office. With only 19 individuals who are licensed Physician assistants, we provided active field coverage for the entire NYC Medical Examiner's office 24hours a day, 7 days a week and 365days a year. Our work entails handling every medical examiner case that is to be handed over to the medical examiner the following day and provide them with the history, identification, photos, and actual physical examination of the bodies at the locations that they have expired at. Not to detract from the difficult work that the medical examiners have to do, but without us, they would have to go out to the crime scenes themselves or visit death scenes at various locations in NYC including NYCHA buildings, homeless shelters, schools, highways, parks, etc. We are the eyes and ears for the medical examiners and the official representatives of OCME in contact with families of the deceased at their homes. We are the first responders of OCME that encounter scenes where decomposed bodies with potentially unknown infectious disease such as Ebola may be present. We are the medical specialist of OCME that work closely with NYPD and NYC detectives out in the field. We are the direct consultants for hospital fatalities and approval of cremation requests. There are also 5 other Medicolegal investigators recently pulled from our already limited staff last year to act as the agency tour commanders(city administrators) of the entire OCME agency's day to day functions 24hours a day,7 days a week and 365days a year. Not even the medical examiners are actively on 24hours a day. In some ways you could say that we are medical support staff that works behind the scenes at NYC's only 24 hour emergency room for the decease.

Recent labor management meeting between our union(DC37/Local 768) and OCME management last month was productive in that they said they would do their part to inform you of the difficulty in hiring Medicolegal investigators (who are Physician assistants) at the current base salary. With the continued lack of staffing, overworked underpaid medical legal investigators, difficult and dangerous work conditions and difficult retention of new hires, I am here as the shop steward for the Medicolegal Investigators at OCME to provide you with a glimpse of our

profession and to ask you to consider our current situation at NYC OCME. Here below is a brief summary of who we are and thank you for your time and consideration of this matter.

What Physician Assistants Do

Physician assistants, also known as PAs, are healthcare professionals that are licensed to practice medicine on a team under the supervision of physicians and surgeons. They are formally educated to:

1) examine patients
2) diagnose and treat injuries and illnesses
3) order and interpret tests
4) develop treatment plans and provide treatment
5) perform procedures
6) prescribe medications
7) counsel on preventive health care
8) assist in surgery
9) NOT to be confused with medical assistants

Work Environment

Physician assistants work in physicians' offices, hospitals, and other healthcare settings. Most work full time.

How to Become a Physician Assistant

Physician assistants must complete an accredited educational program. These programs usually lead to a master's degree. All states require physician assistants to be licensed.

Pay

The median annual wage for physician assistants was $90,930 in May 2012. The average salary among all physician assistants (PAs) in 2014 earning between $20,001and $149,999 per year is $100,497.78.

Job Outlook

Employment of physician assistants is projected to grow 38 percent from 2012 to 2022, much faster than the average for all occupations. Increased demand for healthcare services from the growing and aging population and widespread chronic disease, combined with a shortage of physicians, will result in increased demand for healthcare providers, such as physician assistants.

What is a Medico-Legal Investigator (MLI)?

The role of the medico-legal investigator (MLI) is to investigate any death that falls under the jurisdiction of the NYC medical examiner, including all suspicious, violent, unexplained and unexpected deaths. The medico-legal investigator is responsible for the dead person, whereas the local law enforcement jurisdiction is responsible for the scene. The medico-legal investigator performs scene investigations (photography, examination of the body and search for potentially relevant evidence) emphasizing information developed from the decedent, medical history and determines the extent to which further investigation is necessary. The medico-legal investigator also handles and intercepts all hospital related deaths that are called in by all NYC hospitals and determines whether those deaths are to become medical examiner cases. Medico-legal investigators should have a combination of education and skills encompassing extensive areas of medicine and local NYC law. The ability of an MLI is as effective as their ability to translate the

findings at the scene in a form that is functional and effective to the medical examiner they represent. In the past and more recently, the MLI has been summoned to court to advise and provide testimony on cases they have been involved in.

Who can become a Medico-Legal Investigator (MLI)?

The medico-legal investigator in NYC was originally instituted by Dr. Charles Hirsch when he came over to NYC to become the Chief Medical Examiner 25 years ago. He replaced the per diem physicians back in the day with handpicked Physician assistants that could focus solely on the investigation of deaths in NYC rather than as a part time paid gig that was performed by regular physicians after they finish their normal fulltime jobs. The NYC medico-legal investigator is required to be licensed by NY state and have at minimum two years of clinical experience since handling hospital related deaths involves an understanding of the nuances and formalities of the local functioning hospital. Also, the MLI must be the most medically knowledgeable person at the scene to determine if further investigation is necessary.

Do I have to have a degree?

NYC OCME sets the highest standard for formal educational requirements specifically for medico-legal death investigation. All MLIs are required to have a Physician Assistant degree from a qualified program (most currently at a Master's level), passed the PANCE boards and be licensed by NY state. Compared to other states and counties, they only require their applicants to have a degree in Forensic Science, Natural science, Anthropology, Nursing, or any other medically related field that would be useful. With the extensive nature of deaths that occur in NYC that are potentially related to medical issues (including possible prescription drug

overdoses), knowledge of medicine plays a vital role during the MLI's investigation of someone's death.

How do Medico-Legal Investigators (MLI) function in NYC?

Reports of death are called into the Office of Chief Medical Examiner by police precincts and hospitals throughout the city. Each case is assigned to the Medico-Legal Investigator in that respect borough (5 boroughs total) and it is the investigator's responsibility to inquire further into the circumstances in order to decide whether the death falls within the jurisdiction of the Office of Chief Medical Examiner. If the death is attributable to natural causes, then the investigator does not need to take jurisdiction and may refer the case to the decedent's family physician. The responsibility to issue a death certificate would then be that of the physician who recently treated the deceased. On the other hand, if the death is not attributable to natural causes, then it falls within the jurisdiction of the Office of the Chief Medical Examiner and the investigator will have to respond to the scene. Many of these deaths are due to "unnatural" causes such as suicide, homicide, accidents and therapeutic complications. At the scene, if there are reasons for further examination or autopsy, the investigator will order the body to be transported to an Office of the Chief Medical Examiner's facility in that respect borough. When a death has occurred in a hospital, a field investigation generally is not required.

In the past, there were 2-3 MLIs assigned to each of the five boroughs during the day and night, 24 hours a day, 7 days a week including holidays. Currently, there is barely one Medico-Legal Investigator covering each of the five boroughs and on the overnight shift, there is one MLI assigned to cover two boroughs (Manhattan and Bronx, Brooklyn and Staten Island).

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Name: Jennifer Cuervo

Address: 790 E New York Ave Brooklyn NY 11203

I represent: NYU Dental Van

Address:

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Date: 32315

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Name: ANDREW SCHENKEL

Address: 205 THIRD AVE #1W NY NY 10003

I represent: NYU COLLEGE OF DENTISTRY

Address: 345 E 24TH ST NY NY 10010

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Name: Anne Bove

Address:

I represent: President HHC & Mayoral & Executive Council New York State Nurses Association

Address:

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Name: Dr. Ross W. Wilson, Chief Medical Offic

Address: _____

I represent: NYC H/HC

Address: _____

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Name: CHRISTOPHER BROMSON

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I represent: NYC SEXUAL ASSLT. INTIATIVE

Address: 417 OCEAN AVE 11225

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☐ in favor ☐ in opposition

Date: 3/23/15

(PLEASE PRINT)

Name: IRENE NINONUEVO

Address: KINGSBRIDGE HGTS.

I represent: NYC SEXUAL ASSLT INITIATIVE

Address: W 60th ST, NYC 10069

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Date: 3/23/15

(PLEASE PRINT)

Name: Bobby Lee

Address: 2059 1ST Raymond Ave #7E

I represent: Community Activist 10462

Address:

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THE CITY OF NEW YORK Public

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Date: 3-22-2015

(PLEASE PRINT)

Name: ANNA KRIL

Address: 45-02 Dutmars Blvd, Astoria, NY 11105

I represent: ASTORIA/Queens SHAREing + CAREing

Address:

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THE CITY OF NEW YORK public

Appearance Card

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☐ in favor ☐ in opposition

Date: 3/23/15

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Name: Moira Dolan

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I represent: Senior Assistant Director, Research + Negotiations

Address: DC37

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THE CITY OF NEW YORK

public

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 3/23/15

(PLEASE PRINT)

Name: Carmen Charles

Address: 125 Barclay Street NY NY 10007

I represent: President, L420, DC37

Address:

THE COUNCIL
THE CITY OF NEW YORK

public

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 3/23/15

(PLEASE PRINT)

Name: Oscar Alvarado

Address: 125 Barclay Street NY NY 10007

I represent: Special Assistant to the President,

Address: L1549, DC37

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Florence Hutner, General Counsel

Address: 421 E. 26th St.

I represent: Office of Chief Medical Examiner

Address: see above

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK Public

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 3/23/2015

(PLEASE PRINT)

Name: Esterlok

Address: _____

I represent: Access Health NYC - Federation of Protestant Welfare agencies

Address: _____

THE COUNCIL
THE CITY OF NEW YORK Public

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 3/23/2015

(PLEASE PRINT)

Name: Nora Chaves

Address: _____

I represent: Access Health NYC - CSS

Address: _____

THE COUNCIL
THE CITY OF NEW YORK Public

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 3/23/2015

(PLEASE PRINT)

Name: Claudia Calhoon

Address: _____

I represent: Access Health NYC - NYIC

Address: _____

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK Public

Appearance Card

I intend to appear and speak on Int. No. Access Health Res. No. NYC

☐ in favor ☐ in opposition

Date: 3/23/2015

(PLEASE PRINT)

Name: NOILYN MENDOZA

Address:

I represent: @ Access Health NYC - CACF

Address:

THE COUNCIL
THE CITY OF NEW YORK Public

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: March 23, 2015

(PLEASE PRINT)

Name: Bobby Lee

Address:

I represent: Public Session of HHC

Address:

THE COUNCIL
THE CITY OF NEW YORK Public

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: March 23, 2015

(PLEASE PRINT)

Name: Kent Mack

Address:

I represent: Public Session of HHC

Address:

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Public

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 3/23/15

(PLEASE PRINT)

Name: Lorraine González-Camastra

Address: _____

I represent: Children's Defense Fund-NY

Address: 15 Maiden Ln, Ste 1200, NYC 10038

THE COUNCIL
THE CITY OF NEW YORK

Public

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 3/23/15

(PLEASE PRINT)

Name: Alana Levitan

Address: _____

I represent: Citizens' Committee for Children

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Public

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 03/23/15

(PLEASE PRINT)

Name: Chris Norwood

Address: 552 Southern Blvd

I represent: Health Republic

Address: _____

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Public

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: MARCH 23, 2015

(PLEASE PRINT)

Name: ALEX LEUNG

Address: _____

I represent: NEAR COLEGAL INVESTIGATORS @ OCME

Address: ALL 5 BOROUGHS

THE COUNCIL
THE CITY OF NEW YORK

Public

Appearance Card

I intend to appear and speak on Int. No. Budget Res. No. _____

☒ in favor ☐ in opposition

Date: 3/23/15

(PLEASE PRINT)

Name: JACQUELINE REINHARD

Address: _____

I represent: EXECUTIVE DIRECTOR, SHARE

Address: 1501 BROADWAY · NY, NY 10036

Public

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. Budget Res. No. _____

☒ in favor ☐ in opposition

Date: 3/23/15

(PLEASE PRINT)

Name: IVIS SAMPAYO

Address: _____

I represent: SR. DIRECTOR OF PROGRAMS, SHARE

Address: 1501 BROADWAY, NY, NY 10036

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK Public

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Deborah Pollack

Address: 1653 Amsterdam Ave

I represent: Communities for Healthy Food

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 3-23-15

(PLEASE PRINT)

Name: Dina Maniotis

Address: 421 East 26th St.

I represent: NYC. OCME

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Barbara Sampson

Address: 520 First Ave NY NY

I represent: OCME

Address: 520 First Ave.

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 3/23/15

(PLEASE PRINT)

Name: FRANK DEPAOLO

Address: 520 1ST AVE, NY, NY, 10016

I represent: OCME

Address: 520 1ST AVE, NY, NY, 10016

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 3/23/15

(PLEASE PRINT)

Name: Marlene Zurack, CFO

Address: _____

I represent: NYC HHC

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 3/23/15

(PLEASE PRINT)

Name: LaRay Brown, Senior Vice President

Address: _____

I represent: NYC HHC

Address: _____

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 3/23/15

(PLEASE PRINT)

Name: Dr. Ram Raju, President

Address: _____

I represent: NYC H/HC

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 03/23/15

(PLEASE PRINT)

Name: Sonia Angell

Address: _____

I represent: DOHMH

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 03/23/15

(PLEASE PRINT)

Name: George Askew

Address: _____

I represent: DOHMH

Address: _____

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 03/23/15

(PLEASE PRINT)

Name: Homer Venters

Address: _____

I represent: DOHMH

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 03/23/15

(PLEASE PRINT)

Name: Gary Belkin

Address: _____

I represent: DOHMH

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 03/23/15

(PLEASE PRINT)

Name: Mary Bassett

Address: _____

I represent: DOHMH

Address: _____

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 03/23/15

(PLEASE PRINT)

Name: Sam Miller

Address: _____

I represent: DOHMH

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 03/23/15

(PLEASE PRINT)

Name: Oxiris Barbot

Address: _____

I represent: DOHMH

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 03/23/15

(PLEASE PRINT)

Name: Sandy Rozza

Address: _____

I represent: DOHMH

Address: _____

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 03/23/15

(PLEASE PRINT)

Name: Charon Gwynn

Address: _____

I represent: DOHMH

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 03/23/15

(PLEASE PRINT)

Name: Jay Varma

Address: _____

I represent: DOHMH

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 03/23/15

(PLEASE PRINT)

Name: Marisa Raphael

Address: _____

I represent: DOHMH

Address: _____

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 03/23/15

(PLEASE PRINT)

Name: Daniel Kass

Address: _____

I represent: DOHMH

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 03/23/15

(PLEASE PRINT)

Name: Debbie Kaplan

Address: _____

I represent: DOHMH

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 03/23/15

(PLEASE PRINT)

Name: Aletha Maybank

Address: _____

I represent: DOHMH

Address: _____

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 3/23/15

(PLEASE PRINT)

Name: Julie Friesen

Address: Deputy Commissioner, Administration

I represent: DOHMH

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 03/23/15

(PLEASE PRINT)

Name: Marie Casalino

Address: _____

I represent: DOHMH

Address: _____

Public

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Courtney Bryan

Address: (Request funding from the City Council)

I represent: The Center for Court Innovation

Address: _____

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK Public

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 3/23/2015

(PLEASE PRINT)

Name: Anthony Feliciano

Address: _____

I represent: ACCESS HEALTH NYC - CPHS

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. Budget Res. No. _____

☑ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Michelle Villagomez

Address: _____

I represent: ASPCA, Director of Legislative Affairs

Address: _____

THE COUNCIL
THE CITY OF NEW YORK Public

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: March 23, 2015

(PLEASE PRINT)

Name: Dr Matthews Hurley

Address: 50 Broadway

I represent: Doctors Council SEIU

Address: _____

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK Public

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 3-23-15

(PLEASE PRINT)

Name: Marilyn Saviola

Address: 25 Elm Place Brooklyn

I represent: Independence Care System

Address: 25 Elm Place Bk, NY

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 03/23/15

(PLEASE PRINT)

Name: Beverly Grossman

Address: _____

I represent: CHCANYS

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 03/23/15

(PLEASE PRINT)

Name: Reed Vreeland

Address: 500 Saint Johns place, Brooklyn, NY

I represent: Housing Works

Address: 57 Willoughby Street, Brooklyn NY

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK Public

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 03/23/15

(PLEASE PRINT)

Name: Constance Robinson-Turner & Dr. Andrea Schenkel & Jennifer Cerva

Address:

I represent: NYU Dental School - Smiling Faces, Going Places Dental VAN & Clinic

Address:

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 3/23/15

(PLEASE PRINT)

Name: Dr. Homer Venters

Address: Assistant Commissioner General Health

I represent: DOHMH

Address:

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 03/23/15

(PLEASE PRINT)

Name: DAN LOWENSTEIN

Address: 45 BROADWAY, 10006

I represent: PARK ROW CHARGE DEVELOPMENT CORP

Address:

Please complete this card and return to the Sergeant-at-Arms