NYC HEALTH + HOSPITALS

# New York City Council Hearing

# NYC's Plan for COVID-19 Testing and Contact Tracing

**Committee on Hospitals**

**&**

**Committee on Health**

**Mitchell Katz, M.D.**

**President and Chief Executive Officer**

**NYC Health + Hospitals**

**May 15, 2020**

Good Morning Speaker Johnson, Chairwoman Rivera, Chairman Levine, members of the Committee on Hospitals, and Committee on Health. I am Dr. Mitch Katz, President & CEO of the NYC Health + Hospitals (Health + Hospitals). Thank you for the opportunity to testify before you on ***NYC's Plan for COVID-19 Testing and Contact Tracing***. I'm joined by the leaders of the Test and Trace Corp, our dedicated, multi-disciplinary team that will effectuate testing and tracing on an unprecedented level. Dr. Ted Long is the Executive Director of the Test and Trace Corp; Jackie Bray is the Deputy Executive Director; Dr. Andrew Wallach is the Chief Medical Officer; Dr. Jay Varma is the Mayor's Senior Advisor for Public Health; and Dr. Demetre Daskalakis is Deputy Commissioner for Disease Control. Although not present for today's hearing, Dr. Neil Vora, recently joined the team as the Director of Tracing; and Dr. Amanda Johnson, is Director of Isolation.

This esteemed group represents some of the best and the brightest across Health + Hospitals, the NYC Department of Health & Mental Hygiene (DOHMH), and the Mayor's Office, working together towards our common goal of suppressing COVID-19. I want to begin today with a thank you to the men and women from Health + Hospitals and DOHMH. They didn't ask for this crisis. But their work on the front lines in our hospitals and clinics these past two months saved the lives of countless New Yorkers.

As you know, last Friday the Mayor announced the creation of the Test and Trace Corps, which will lead a comprehensive plan to test, trace, and take care of every case of COVID-19. All three programs are now under a unified operational structure, leveraging Health + Hospitals high-level testing and treating organizational expertise and the world-class contact tracing expertise of the DOHMH. These three programs work best together under one umbrella organization. With more testing,

we have more opportunity to identify contacts, when we identify contacts, we need places for them to go and be isolated and provided with medical care. It must all work together to succeed.

Health + Hospitals has been the leader in COVID-19 testing and building out the City's testing capacity. We have also stood up a hotel program with a comprehensive clinical model to appropriately isolate individuals diagnosed with COVID-19. This is a huge operational wheel to manage and higher up 1,000 people in a very short time. I'm proud that Health + Hospitals has the infrastructure to rapidly hire, while benefiting from the expertise of DOHMH.

This work is an essential precursor to fully and safely re-opening New York City. Health + Hospitals will build on our core strength of operationalizing patient testing and care in an accessible, efficient, culturally sensitive way, and we will continue to partner with DOHMH to integrate their renowned expertise in contact tracing. This is a massive and complex endeavor, which requires a single, unified command, and all components fully integrated both technically and administratively. In addition, Health + Hospitals will utilize its nimbleness as a public benefit corporation, to hire and scale up quickly. We are a vast and well managed health care delivery system that serves every community, every kind of New Yorker. People trust us with their health, regardless of immigration status or ability to pay. We have some of the finest doctors and nurses in the world. And we are ready for this challenge.

We've already been at this work for weeks. Health + Hospitals has stood up 23 community testing sites at our community health centers and our acute care facilities, and will expand by another 12 sites by mid-May. Our goal is to expand from almost 14,000 tests per day now to 50,000 tests per day by August. By expanding our testing capacity, we will be able to identify those who test positive, trace all their close

contacts as part of an integrated program. To do so effectively and equitably, we will be focusing on communities across the five boroughs, operating outside of traditional clinic and hospital settings to make care as accessible and community-focused as possible. This will include leveraging existing City infrastructure and properties. Partnering with community clinics, the City will support providers who serve in the hardest-hit neighborhoods to expand testing capacity.

The Test and Trace Corps is currently recruiting, training, and hiring 1,000 contact tracers to investigate cases, trace and monitor contacts, and manage all case data and inquiries by June 1. To date, we have received approximately 10,000 applications, and are encouraging more as we will need 5,000 or more people once we are fully operational. DOHMH will transfer 40 of its experienced contact tracers to Health + Hospitals, and will supervise, train, and ensure the quality of the work by our incoming contact tracers. This program will allow the City to immediately identify, isolate and care for those who test positive for the virus, and then rapidly track, assess, and quarantine people they may have infected.

The Test and Trace Corps will also work with each person who has COVID-19 to connect them immediately to care and help them safely isolate at home, a hotel, or a hospital and ensure their close contacts are rapidly traced, assessed, and quarantined at home or a hotel, as necessary. Health + Hospitals already has a hotel program in place for New Yorkers requiring quarantine or isolation for up to 14 days, where they have transportation to and from the hotels, they receive meals, wellness checks, support services, health home coordination, and home care. We will work with the City to expand the current capacity to 1,200 hotel rooms by June. If more isolation rooms are needed, we can quickly build out that number. At the hotels, meals, clean

clothes, and medication refills for anyone who is isolated and quarantined who may require assistance will be provided. New Yorkers with COVID-19 will be connected to a comprehensive range of support services such as grocery delivery to help them isolate at home. Using tele-medicine, the Health + Hospitals will perform remote medical checks on those in isolation and quarantine and evaluate individuals with symptoms to determine whether they should receive care at a hospital or not.

Thank you for your time this morning, and I will answer any questions you may have.

# New York City's Public Healthcare Workers Union

LOCAL 420
DC 37, AFSCME, AFL-CIO

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Written Testimony
Carmen Charles
President: Local 420, DC37, AFSCME, AFL-CIO
New York City Council Committee on Health and Committee on Hospitals
Re: **New York City's Plan for COVID-19 Testing and Contact Tracing**.

Good afternoon Chairs Levine and Rivera, and members of the New York City Council's Committees on Health and Hospitals. My name is Carmen Charles and I am the President of ASCME, Local 420: NYC's Municipal Hospitals Workers Union. We thank you for holding this crucial and time oversight hearing.

Local 420 represents more than 8,700 members across the 11 acute hospitals, 5 long-term care facilities and the plethora of clinics across the City that are run by NYC Health + Hospitals, along with the technicians and aides employed at the Office of the Chief Medical Examiners' Office, Fire Department and Department of Corrections.

We endorse Mayor Bill de Blasio's plan to entrust the City's COVID-19 testing and contact tracing program to NYC Health + Hospitals.

Local 420 believes that for our state to safely reopen, we must develop the capacity to regularly test portions of the population, trace the spread of COVID-19 and isolate individuals that have been exposed.

Today, the Finger Lakes, Southern Tier and Mohawk Valley will start reopening their economies. Each hour, New York City inches closer to meeting Governor Andrew Cuomo's metrics to safely reopen. We would not be here without the sacrifice and hard work of healthcare workers, including Local 420 members.

The COVID-19 pandemic has had a historic impact on our City. My members have served on the frontlines of what has been a war to protect our City's most vulnerable residents. Local 420 members have worked long hours, often without the proper personal protective equipment, to provide aid and comfort to New York City in its darkest hour.

At times, the war against COVID-19 seemed bleak but I knew that our City would hold the line because of the dedication and professionalism of Local 420 members and our colleagues at the NYC Health + Hospitals.


70 West 36th Street, 16th Floor, New York, NY, 10018. Tel: (347) 532-6420 Fax: (347) 532-6432
E-mail: info@local-420.org Web: www.local420union.org Twitter: @L420AFSCME Facebook: Local420AFSCME

# New York City's Public Healthcare Workers Union

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New York City is the epicenter of the nation's COVID-19 pandemic, NYC Health + Hospitals facilities such as Elmhurst, Kings County and Lincoln treated our fellow New Yorkers at the epicenters of the epicenter. The large volume of COVID-19 patients at NYC Health + Hospitals facilities have helped the system develop an expertise about COVID-19 that is second to none. This knowledge is not without sacrifice. To date, 13 members of Local 420 have lost their lives to COVID-19. They are heroes that deserve our City's respect and praise.

NYC Health + Hospitals has the earned the right to administer the City's testing and contact tracing program. We are aware that there is concern about whether NYC Health + Hospitals can handle undertaking such an ambitious program.

We within Local 420 have no doubt that our City's public health system can meet the challenge. From the COVID-19 pandemic, we have seen how effective NYC Health + Hospital is at improvising, adapting and overcoming every challenge raised by this virus. We have confidence that the Health+Hospitals system will work with the Department of Health and Mental Hygiene to learn from their experiences with contact-tracing diseases such as tuberculosis, HIV and Ebola. NYC Health + Hospitals and the Department of Health and Mental Hygiene have worked effectively together for decades; we can continue doing so for this important mission to help us re-open our City's economy and bring back some sense of normalcy.

In closing, I want to take a moment to express my union's sympathy to the families of all of the people lost to COVID-19 and want to thank all frontline workers for their exemplary service and sacrifice to our City in its time of need.

Thank you.

Carmen Charles
President


70 West 36th Street, 16th Floor, New York, NY, 10018. Tel: (347) 532-6420 Fax: (347) 532-6432
E-mail: info@local-420.org Web: www.local420union.org Twitter: @L420AFSCME Facebook: Local420AFSCME

**New York City Council, Committee on Health and Committed in Hospitals Joint Hearing: "NYC's Plan for COVID-19 Testing and Contact Tracing."**
**Friday, May 15th, 2020**

Good afternoon. My name is Hallie Yee, and I am a Policy Coordinator at the Coalition for Asian American Children and Families (CACF). Thank you, Chair Levine and Chair Rivera, and members of each committee for holding this important hearing.

Since 1986, CACF is the nation's only pan-Asian children and families' advocacy organization and leads the fight for improved and equitable policies, systems, funding, and services to support those in need. The Asian Pacific American (APA) population comprises over 15% of New York City, over 1.3 million people. Yet, the needs of the APA community are consistently overlooked, misunderstood, and uncounted. We are constantly fighting the harmful impacts of the model minority myth, which prevents our needs from being recognized and understood. Our communities, as well as the organizations that serve the community, too often lack the resources to provide critical services to the most marginalized APAs. Working with almost 50 member organizations across the City to identify and speak out on the many common challenges our community faces, CACF is building a community too powerful to ignore.

This pandemic has exacerbated long-standing and interconnected crises in socioeconomically disadvantaged communities. While unfortunate and heartbreaking, this was not entirely unexpected. Our APA communities are historically overlooked and our needs misunderstood or entirely uncounted. We are constantly fighting the harmful impacts of the model minority myth, which prevents the community's needs from being acknowledged and understood. This means our communities often lack the resources to provide critical services for those in need. Never has this been more apparent than right now.

We have convened over 30 organizations throughout the community to establish a list of urgent concerns we see in our communities. The following initial calls to action must be met to begin the process of redress and revitalization of APA communities most impacted by COVID-19:

- **Specific and granular disaggregated data on infection rates, hospitalizations, and deaths in the APA community:**
  APAs hail from South, Southeast, East, and Central Asian countries, as well as from the Pacific Islands. In NYC, we represent over 40 ethnicities, tens of languages and religions, and a multitude of cultures and immigration experiences. This has consistently been a focus of our coalition as our communities are often miscounted or dubbed "other" out of a misunderstanding of the APA community as a whole. Local Law 126 requires City agencies to collect disaggregated data by ethnicity by providing respondents the option of choosing from at least the top 30 largest ancestry groups and languages spoken in the city of New York based on data from the United States census bureau; and "other," with an option to write in a response. This, however, does not extend to the Health and Hospitals Corporation.

  As of April 22, 2020, there were 830 deaths from COVID-19 associated with individuals

identifying as Asian American. At the same time, some 1,065 COVID-19-related deaths were relegated to the "other" or "unknown" race categories, which represents about 9% of the nearly 11,700 city deaths that had been logged by the NYC Department of Health and Mental Hygiene through that date. The City relies on lab reports and medical records to identify the race or ethnicity of those who died of the virus. When the information is missing, victims are categorized as "unknown." And while the information regarding COVID-related deaths are available each day, the breakdown by race is sporadic and by ethnicity non-existent. Knowing which communities are most heavily impacted by COVID-19 is challenging when there is no data available for which racial demographics are testing positive, needing hospitalization, recovering from COVID-19, and dying as a result of COVID-19. Tracking and publishing this data is **crucial** in determining which zip codes and neighborhoods receive the resources they need.

- **All manners of testing in APA communities, including the testing of essential workers, the availability of rapid testing, and increasing the number of test sites and mobile test centers especially in underserved neighborhoods:**
  APA populations inhabit some of the neighborhoods hardest hit by the coronavirus. A large proportion of APAs live in central Queens, southern Brooklyn, and The Bronx — all areas with a high share of workers in food preparation, delivery, janitorial services and construction. Elmhurst, Jackson Heights and Corona — arguably the city's hardest hit neighborhoods — are home to at least 10% of all APA New Yorkers and nearly 40% of the population of those neighborhoods, according to the U.S. Census' American Community Survey latest estimates. In fact, a number of our community organizations are conceptually supportive of being used as additional testing sites. However, they require a level of accountability from the City that has not yet been met but would benefit from community response teams. Of course, the distribution of additional testing resources to these neighborhoods would best be served by having an accurate and precise count of APAs who have contracted the virus. Even without that disaggregated data, however, the City is aware that these areas of the city that are home to greater proportions of people of color and are seeing high hospitalization rates and high percentages of positive results. Resources should therefore be targeted to these pockets of significant impact.

- **Additional resources in-language for Low-English Proficient communities, with special attention to low-incident APA languages:**
  COVID-19 has highlighted the barriers the most marginalized APAs face to language access. Per Local Law 30, the Health and Hospitals Corporation is required to provide intake forms in the top 10 languages in New York City: Arabic, Urdu, French, Polish, Spanish, Chinese, Russian, Bengali, Haitian Creole, and Korean. Yet, numerous articles and reports have come about during this pandemic describing the lack of language assistance throughout various hospital systems, the COVID-19 City Hotline, and mobile test centers. The delay of disseminating in-language information about the pandemic, including the social distancing guidelines has led to a higher risk of exposure to the virus for the most vulnerable in the APA community. This egregious gap in language access has led to our communities to rely once again upon the community-based

organizations (CBOs) who serve them in the absence of proper resources by the City as CBOs act as interpreters and crowdsource translated materials regarding even the most basic of information on the pandemic. Outreach to the most marginalized pockets of the community must be prioritized, and patients need the availability of quality and consistent interpretation within the healthcare systems - without it, their health and very lives are endangered if they are unable to communicate with their healthcare providers

This list of demands is, of course, not exhaustive. Our communities are consistently overlooked in the distribution of resources, which is harmful to us as well as other communities of color who are denied the same resources due to the perceived "success" of APAs. This pandemic has highlighted a myriad of holes in our City's safety net systems, and the City's response must address root problems in addition to immediate needs. Our community will continue to suffer every day we allow these flaws in the system to exist.

We thank you, Chairs Levine and Rivera, for your leadership in taking steps to assess and address the disparate impact of COVID-19 on communities of color, including the APA immigrant community. We look forward to continuing working with New York City to ensure that the most vulnerable New Yorkers have equitable access to the resources and services necessary during this crisis.


Kelly Grace Price • co-creator, Close Rosie's • 534 w 187th st #7 New York, NY 10033
• E-Mail: gorgeous212@gmail.com
Web: http://www.CloseRosies.org

May 15, 2020

**To:** Councilwoman Carlina Rivera: NYC Committee Chair Committee on Hospitals

**To**: Speaker Corey Johnson, Councilman Robert Holden, Councilman Daniel Dromm, Councilwoman Helen Rosenthal, Councilwoman Deborah L. Rose , Councilman Keith Powers, Councilman Stephen Levine et al

**Via email**:

**Ref NYC Council Oversight of Covid-19 Contract Tracing**

Dear Chairwoman Rivera, Committee Members and Committee Counsel(s):

I thank you for holding this hearing and also the other members of the council and staff for allowing me to appear today and speak. I am Kelly Grace Price, founder of Close Rosie's (http://www.CloseRosies.org). I for many years before my false arrest, unlawful detention and malicious prosecutions worked in top-tier international technology and business as a technology architect and project manager for complex financial and media systems for a corporation privately owned by Bill Gates and banks like JP Morgan/Chase. I appear today to submit comment on the broad outlines of the contract-tracing program as has been presented to date. I have been advocating for accountability and oversight of the NYPD, CCRB and City DAs for the better part of a decade since my false arrests, unlawful detention and malicious prosecutions in 2011 that ended in full dismissals. One

of the narrative thrusts of my advocacy has been to target the NYPD and borough DA's use of PALANTIR that creates algorithms that analyze each citizens credibility when making complaints to the NYPD etc. Despite my advocacy efforts there is still nary any oversight of these systems and I fear the same potential ebbing within the current effort by H&H to build a covid-19 contract-tracing entity.

Today I wish to quickly broach four main points:

1. **Oversight of current NYC technology is oblique, inadequate and byzantine.**
   A. Why is Jessica Tisch involved? Her track record is dispositive and her family's financial and social ties to Palantir, K2 Intelligence, the Knoll family and the shadowy murky world of law-enforcement technology. Why isn't she here testifying today? From the testimony of H&H the buck seems to be stopping with her ref Covid-19 tracing technology & data. We need MORE details about the architecture of the technology. Will the data be deleted at some point? "COMCARE" is being built w the state to loop in other areas of the state and the build-out for NYC will be ready June 1. Is COMCARE using Salesforce too as well as the tool NYC is building so these platforms are compatible?

   B. SALESFORCE?
      i. Will the server admins and database administrators at salesforce have access to our health data in the same way that the techs and admins at Palantir have access to our NYPD profile data?
      ii. Is there a backup environment? Has it already been built and put through a test/environment with de-bugging and Q&A?
      iii. Security: Salesforce stores all data in a CLOUD: is this really the security we need for this data?
      iv. Salesforce has so many known security and database issues. Who made this choice?
      v. Salesforce is well-known to be involved in politics: they even have a political PAC that has given to NY Politicians who lead districts that H&H Hospitals happen to be located in.
      vi. After 9/11 we had a rush to use tech to trace potential terrorists, to monitor them

and identify. When the Patriot Act was rushed through we allowed many egregious tech infringements of our rights that weren't "cancelled" by the sunset clause. What is the plan for destroying this data when the need for tracing is over and/or when a patient heals/goes home from quarantine? Is there a sunset clause that times-out this program and outlines a protocol for destruction of this data?

2. **I 100% agree with CW Inez Barron. This data will be subpoenable by the NYPD/DAs. How will this data be protected? How long the data will be held and who will have access to it?** I heard Dr. Ted Long respond to Chari Rivera's question of "who will own this data" with a condescending sidestep that DID not respond to her question: he said they are looking at "apps" but that doesn't answer question of who will own this data.
   A. People on parole will be subject to accusations of parole violations: currently technical parole violations are still being interred into our City jails: for women this is the #1 reason we have been caged on Rosie's since March 12th when I began tracking the data. What are the safeguards that will be built in preventing federal marshals, parole officers, DAs, NYPD, law-enforcement/ICE getting their hands on this data?
   B. Everyone I know buys weed. No one calls there weed dealer we just go to the corner store of the spot they operate out of. No one will give up these contacts bc we don't have them and also we don't want our weed dealers arrested. Same applies for sex workers. Right now on my block there is a heroine dealer operating from under the scaffolding build around the Yeshiva synagogue: do you think the zombies that congregate there every night and make the synagogue steps a shooting gallery will give you his phone #?
   C. Again the H&H doctor who responded to her sidestepped CW Barron's question. Is this mandatory? What if people refuse? Will they be arrested if they resist? Dr. Katz DID NOT answer CS Barron question of what will happen if people refuse to participate? CM Moya repeated questions about data safety but he still didn't get an answer. Katz says they will not share or sell data but we need these guarantees built-in from the beginning.

3. **Who are the people being hired to be "disease detectives?" If they are "from the**

**communities most effected are they ex cops?** I've heard that the people being hired have been for the most part NYPD Auxiliary cops? Who are these people? Can we make sure social workers women are hired instead of retired cops, auxiliary cops and retired law enforcement? Have members of the NYPD/retired/auxiliary/ family members being given priority in hiring? **Can we call them something else other than "Detectives?"**

4. **NYC H&H is vastly inadequate**: they can't even manage the population of 9/11 survivors still living in the city with dangerous respiratory conditions: how can we expect them to get this right? I've been trying to get MH care from the 9/11 Survivors' program for over two years and STILL have not been enrolled in full-time care. This agency is so over-burdened and caustic I can't understand how they think they can shoulder this responsibility.

Thank you very much for considering my comments in forming your oversight to this program.

Best,

Kelly Grace Price

http://www.CloseRosies.org

Ft. George, Manhattan

May 15, 2020

BLACK HEALTH
National Black Leadership Commission on Health, Inc.

New York City Council
Committee on Health Jointly with the Committee on Hospitals
Virtual Public Hearing
New York City, NY

Friday, May 15, 2020

Statement by C. Virginia Fields
President and CEO National Black Leadership Commission on Health, Inc.

For over two centuries, the New York City Department of Health and Mental Hygiene (NYC DOHMH) has worked tirelessly improving the health and wellbeing of New Yorkers integrating principles from cutting edge public health practices and grass roots collaboration. Further, the NYC DOHMH has worked with one of the most culturally and ethnically diverse populations in one of the world's most populous cities. Today, it stands as one of the nation's largest public health systems. No organization in the nation is so aptly positioned, given its experience and expertise, to address the population-level public health approach to the COVID-19 pandemic (SARS-CoV-2) in New York City.

Based on the expertise of preeminent infectious disease professionals, a plan that features rigorous testing and contact tracing, is New York City's most promising approach to stymie the spread of COVID-19. Mayor De Blasio must provide the NYC DOHMH with the authority and resources to lead the contact tracing efforts so that they will be carried out in adherence with established epimidimiological principles. Putting Health and Hospitals (H+H) in charge of the contact tracing efforts will not only take away from their central role of coordinating the care and healing the sick of New York City, but will also result in a delayed and possibly weaker contact tracing program. The NYC DOHMH has centuries of experience and an established [contact] 'Testing and Tracing Program' currently in place. We, as New Yorkers, do not have the time to wait for H+H to get up to speed. We need our extensive, existing, and well-trained team of experts to have the authority and resources to act now!

The Health and Hospitals (H+H) organization has been tasked with the Herculean effort of quickly adapting and responding to the sharp increase in hospitalizations due to the unprecedented public health crisis. The National Black Leadership Commission on Health (NBLCH) agrees wholeheartedly with Mayor De Blasio's statements praising H+H for their "speed and intensity and precision" in the city's response to the COVID-19 pandemic. Their coordination and leadership have undoubtedly saved the lives of many New Yorkers and their continued dedication to the fight against the pandemic will be crucial in keeping the city and state healthy.

H+H has been asked to amend hospital and organizational policy to address the ever-changing needs of the city's COVID-19 response. As such, they have been working with an admirable amount of flexibility not usually expected from this organization. Given these immense, existing changes to the fundamental policies of NYC's H+H, it is ill-advised to delegate them the responsibility for managing yet another bit of uncharted territory—contact tracing. Fortunately, New York City's

DOHMH is exceedingly well-equipped to step into this role. This epidemic has taken a grave toll on our communities. Now, more than ever, we reemphasize the dire need to listen and act according to the public health experts.

Contact tracing is a cornerstone practice in infectious disease containment and is a proven, proactive method to stopping the spread of infectious diseases such as Ebola, SARS-1, MERS, and Tuberculosis. In the 20th Century, contact tracing allowed New York City health officials to identify and quarantine the infamous "Typhoid" Mary Mallon and has the potential to greatly mitigate the continued spread of the Novel Coronavirus today. Without contact tracing, the city relies on the number of hospital admissions or positive tests to evaluate the effects of its mitigation efforts. This is a reactionary approach and cannot continue as our only form of epidemic program evaluation.

The contact tracing plan in New York City, at this point, remains incomplete. A number of questions are yet to be answered in terms of scope, technology, privacy, and even seemingly simple questions such as "What constitutes 'contact'?". These questions must be addressed by experts from both the DOHMH as well as H+H so that New York City can create the most effective program. This task would be better served under the management of the NYC DOHMH and not H+H.

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**Solving the School Nurse Crisis Before Schools Reopen**

Kim Watkins

Long before COVID-19, New York City schools were dealing with a public health crisis: a lack of full-time nurses. Despite operating more than 2,000 schools, the city only employs around 1,400 nurses. It outsources others through private companies, wasting precious tax dollars, more than $100 million per year, on profiteering vendors rather than investing in the nursing staff that our schools need. And that they will need even more once schools open back up.

On Thursday evening, the Panel for Educational Policy approved two emergency contracts to hire additional private nurses for schools, a move that city leaders say is needed to ensure that enough nurses will be available to open schools. However, this approach will only perpetuate a major problem that has been developing for nearly a decade. New York City schools must employ at least one full-time nurse in each school building.

In March, Mayor de Blasio made a promise to have a nurse in each school, but he brought in 85 nurses to assist in filling more than 400 vacancies. It made no progress toward the level of health care that our schools need.

New York City leaders keep sweeping this problem under the rug. With a shortage in the nursing profession, two employment castes along with two union contracts, and an increasing need for medical care within the student population, the work has become one of those complicated issues that is often treated with equal parts passion and paralysis in the offices of elected officials.

Back in late 2018, me and my colleagues from the Community Education Council, District 3 (CEC3), held a public meeting where Dr. Roger Platt, from the Office of School Health, explained the employment structure to Upper West Side and Harlem parents. We couldn't believe how flawed the organization seemed to be, to have roughly 2,000 schools - public, charter, parochial, and private - serviced by only 500 nurses who are employed by the Education Department and 900 nurses employed by the Health Department. This pool of 1,400 “full-time” or permanent nurses had to be supplemented by hundreds of other nurses who were hired via private vendor contracts.

Union contract agreements complicated the matter further, because as it was later discovered, only the Department of Education (DOE) nurses are really full-time. With the support of the United Federation of Teachers (UFT), these coveted nursing positions enjoy salaried work with benefits and pension, working the school year like most teachers. The Department of Health (DOH) nurses are permanent employees but paid an hourly wage (not equal to that of DOE nurses) and overtime. Some, plus DOH nursing supervisors, are also expected to work throughout the year, and their benefits are not as robust as those of the DOE nurses. These nurses are represented by DC37.

Looking to private nursing companies to staff schools, so as not to deal with the full-time employment issue, seems to be the main driver for so many agency contracts, but there are serious problems with this rationale. For starters, taxpayers are paying for the profits made by the private vendors, who don't typically pay their nurses all that well. Outsourcing essential government jobs wastes money and also falls short on the quality of work that is needed.

More importantly, unlucky schools without a full-time nurse often don't know who will be serving their students. Often these are the schools with higher rates of asthma, diabetes, and other conditions that demand medical attention for students. Some schools in Northern Manhattan and the South Bronx have asthma rates as high as 40%. Other health conditions are also on the rise, many of which require daily care such as injections, catheterizations, and medication administration.

Contract nurses sent in as subs also don't even have access to the "Automated Student Health Record" (ASHR) system. When they see a sick student, they have to rely on accurate written records, if any. They complete a written document of the visit, which technically should be entered into ASHR but isn't. ASHR also informs New York City's "syndromic surveillance" capabilities, a database of citywide disease information that is more important than ever.

Before the pandemic, more than 50 New York City schools operated without a nurse on staff at any given day. This led principals to make more 911 calls, taxing our emergency response system. They also had to place calls to parents with children who require skilled nursing care, leading to higher student absence rates. Some parents simply pulled their children out of the DOE and resorted to homeschooling.

To nursing supervisors, this patchwork system has meant a persistent shifting around of schedules, absences, and other issues related to working with independent contractors. It held up the heavy data flow of information related to medication administration forms, because they too get entered into ASHR. But this particular task is a constant reminder of how flawed the school nurse structure is for student care.

New York City has not prioritized school nurses for years. COVID-19 has shown us all how essential our school nurses are and will even more so when school buildings open again. The Panel for Educational Policy vote on private vendor contracts highlights the city's reluctance to deal with the problem fairly and equitably. But there is still time to make progress on this issue.

City leaders can bring the right people together to restructure the employment model and create a pipeline for the hiring process. We need a school system that truly serves our children, and that means that every school should have a full-time school nurse when we resume normal operations in the fall.

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Kim Watkins is a Harlem parent, president of Community Education Council, District 3, and a founding member of Parents Supporting Parents. On Twitter at @kimwatkinsnyc.

CHARLES B. WANG
COMMUNITY HEALTH CENTER
王 嘉 廉 社 區 醫 療 中 心

268 Canal Street, 6th Floor, New York, NY 10013 | Phone 212.379.6988 | fax 212.379.6936

**Charles B. Wang Community Health Center Oral Testimony**
**New York City Council Health Committee**
**NYC's Plan for COVID-19 Testing and Contact Tracing Hearing**
**May 15, 2020**

My name is Kaushal Challa, and I am the CEO of the Charles B. Wang Community Health Center. We are a federally qualified health center with locations in Manhattan and Queens, primarily serving New York City's Asian American community. Last year we served over 60,000 unique patients. 88% of our patients are at or below 200% of the Federal Poverty Level, and 83% are best served in a language other than English.

Our health centers have stayed open for the community throughout this pandemic. We are caring for our patients through both in-person and virtual channels and are proud to be part of the public health response to this crisis.

Testing and tracing will play an important role in our recovery. I would like to share perspectives about two drivers of success for the program.

First, I would like to highlight the importance of having testers and contact tracers with appropriate language skills and cultural understanding for our diverse communities. This is crucial to building trust with our communities and ensuring that there is actionable guidance given to patients. For example, in order to effectively serve the City's Chinese American community, appropriate dialect language ability among program staff must be considered. Among our patient community for example, approximately 50% are Mandarin speakers, and 25% are Cantonese speakers.

Second, I would like to emphasize the need to have protocols in place for providing guidance to patients about their results and ensuring patients understand this guidance. For example, if a patient tests positive, what specific steps should they be taking? If a patient tests negative, is there anything they can do now that they could not do before? Providing results without translating them into a plan of action limits the utility and purpose of testing.

Thank you for the opportunity to share these perspectives. I look forward to the launch of this program.

Kaushal Challa
Chief Executive Officer
Charles B. Wang Community Health Center, Inc.

**ADMINISTRATIVE OFFICE**
60 Madison Avenue, 5th Floor
New York, NY 10010
Tel (212) 545-2400 • Fax (212) 463-8411
www.chnnyc.org

Elizabeth Krob Kellner
*Chair*

Robert Hayes
*President/CEO*

**BRONX**
Bronx Health Center
975 Westchester Ave., Bronx, NY 10459
Tel (718) 320-4466 • Fax (718) 991-3829

Tremont Health Center
4215 Third Ave, 2nd Fl., Bronx, NY 10457
Tel (718) 294-5891 • Fax (718) 294-2468

**BROOKLYN**
CABS Health Center
94-98 Manhattan Ave., Brooklyn, NY 11206
Tel (718) 388-0390 • Fax (718) 486-5741

Caribbean House Health Center
1167 Nostrand Ave., Brooklyn, NY 11225
Tel (718) 778-0198 • Fax (718) 221-8169

Dr. Betty Shabazz Health Center
999 Blake Ave., Brooklyn, NY 11208
Tel (718) 277-8303 • Fax (718) 277-4795

**MANHATTAN**
Helen B. Atkinson Health Center
81 W. 115th St., New York, NY 10026
Tel (212) 426-0088 • Fax (212) 426-8367

Community League Health Center
511 W. 157th St., New York, NY 10032
Tel (212) 781-7979 • Fax (212) 781-7963

Catherine M. Abate Health Center
150 Essex Street, New York, NY 10002
Tel (212) 477-1120 • Fax (212) 477-8957

Seward Park Campus SBHC
350 Grand St., Rm. 240, New York, NY 10002
Tel (212) 432-8490

**QUEENS**
Long Island City Health Center
36-11 21st St., Long Island City, NY 11106
Tel (718) 482-7772 • Fax (718) 482-9648

Queens Health Center
97-04 Sutphin Blvd., Jamaica, NY 11435
Tel (718) 657-7088 • Fax (718) 657-7092

Family Health Center
90-04 161st St., Jamaica, NY 11432
Tel (718) 523-2123 • Fax (718) 523-5833

**Medical Mobile Van**
Tel (212) 545-2495

**Office Locations:**

345 E. 102nd St., 4th Fl., New York, NY 10029
Tel (212) 360-8080 • Fax (212) 828-2325

170 Broadway, Brooklyn, NY 11211
Tel (718) 486-4933

975 Kelly St., Bronx, NY 10459
Tel (718) 320-4499 • Fax (718) 862-4497

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**Community Healthcare Network**

05/14/2020

Testimony

I would like to introduce myself, Fernando Valerio, the single Check Hep C Navigator at Community Health Care Network. It has come to my attention while attending meetings with the NYC Department of Health and Mental Hygiene that certain city council funds are earmarked for the NYC Viral Hepatitis C Program.

I have been attending many Hepatitis C related meetings which has been proving to me how important this work actually is. During these meetings I have had the pleasure of meeting individuals who have been affected by Hepatitis C, both individuals who have been cured and individuals that need further assistance with getting cured of this virus. These human beings always show their tremendous gratitude and no words can emphasize what these individuals are feeling and the situation that they are currently going through. One phrase that I hear often from these individuals includes, "My life has been given back to me", and though I have never had to say these words personally, it sends a very powerful message. This is one example showing how important this work is and how much it impacts these people's lives. Now, with a cure for Hepatitis C available, is the time for people like me to make sure that every Hepatitis C positive person seen at my agency has the help needed to assist them through the cure process. With the help of the Check Hep C Program and an available cure for Hepatitis C, now it is possible and the time to erratic this virus from New York City.

Just in New York City alone Hepatitis C affects 146,500 people of whom 40% are unaware that they are infected and only 18% have gotten cured. Treating Hepatitis C reduces the risk of liver disease and premature deaths. The goals of the Check Hep C Program are: (1) to link these individuals to proper medical care, (2) to support this medical care and the success of the treatment, (3) to prevent re-infection of Hepatitis C and (4) to help patients maintain proper liver health.

Sincerely,

**Fernando J. Valerio, Check Hep C Navigator**
Community Healthcare Network
CABS Health Center || Bronx Health Center
718-862-4424, 646-801-6910

**Japanese American Social Services, Inc.**
100 Gold Street, Lower Level, New York, NY 10038
Phone: (212) 442-1541
Web: http://jassi.org E-mail: info@jassi.org

New York City Council Financial Committee
FY 2021 Budget Hearing

Access Health Discretionary Funding FY 2021

Thank you, members of the Financial Committee for your hard work in the face of the COVID-19.

My name is Hiroko Hatanaka and I am a member of the board of Japanese American Social Services, Inc. (a.k.a. JASSI).

The mission of JASSI is to improve the quality of life for people living in the New York metropolitan area by providing quality social services at the local community level. For the past 38 years JASSI has been providing services to people who face problems resulting from language barriers, cultural differences, and/or differences in the services systems, and JASSI has been providing these services regardless of age, income, gender, race, ethnicity, or immigration status. All services are provided without any charge.

During the COVID-19 crisis between March 16, 2020 and April 17, 2020, JASSI staff spent over 5,000 hours for COVID-19 related inquiries on health insurance due to loss of jobs, mental health needs, public benefits, entitlement, Medicare and Medicaid. 80 percent of the contacts required assistance in Japanese. The New York Council Access Health NYC Initiative is crucial in supporting such services.

Almost 15% of APAs in NYC ages 18 and over are uninsured and over a majority (89%) of uninsured APAs are foreign-born. Health care access problems are exacerbated in the APA community by immigration status-related challenges and fears, language barriers, cultural stigmas, and low utilization of primary and preventive care. This initiative helps train and inform disenfranchised New Yorkers on their health rights and options.

We are urging the New York City Council to restore $2.5 million to continue in supporting Access Health Initiative funding for the fiscal year 2021, which is critical especially now, in responding to the needs of New York API community in facing the COVID-19 crisis job loss on top of the continuing fears around public charge.

**Japanese American Social Services, Inc**.
100 Gold Street, Lower Level, New York, NY 10038
Phone: (212) 442-1541
Web: http://jassi.org E-mail: info@jassi.org

Thank you for the opportunity to submit our testimony.

Hiroko Hatanaka
Member of the Board

SURVEILLANCE TECHNOLOGY OVERSIGHT PROJECT

@ the Urban Justice Center:
40 Rector Street, 9th Floor
New York, New York 10006
www.StopSpying.org | (646) 602-5600

**STATEMENT OF**
**ALBERT FOX CAHN, ESQ.**
**EXECUTIVE DIRECTOR**
**SURVEILLANCE TECHNOLOGY OVERSIGHT PROJECT ("S.T.O.P.")**

**BEFORE THE**
**COMMITTEE ON HEALTH AND COMMITTEE ON HOSPITALS**
**NEW YORK CITY COUNCIL**

**FOR A HEARING CONCERNING**
**NEW YORK CITY'S PLAN FOR COVID-19 TESTING AND CONTACT TRACING**

**PRESENTED**
**MAY 15, 2020**

## 1. Introduction

Good morning, my name is Albert Fox Cahn, and I serve as the Executive Director of the Surveillance Technology Oversight Project ("S.T.O.P."). S.T.O.P. advocates and litigates for New Yorkers' privacy, fighting discriminatory surveillance. I commend the committees for today's hearing, and I am grateful for the opportunity to discuss the privacy implications of New York City's tracking and contact tracing efforts around COVID-19.

Last week, Mayor Bill de Blasio announced the City's plan to test and trace the spread of COVID-19, with a promise to mobilize 1,000 contact tracers by the end of May.[1] Preliminary information suggests that New York City will use a manual model of contact tracing, and we applaud city officials for refusing to adopt a technology-centered approach, such as those developed by Apple and Google. Still, concern remains over how we will protect the fast amounts of data collected by manual contact tracers. We must launch this expanded tracking effort, but if we don't work deliberately to safeguard New Yorkers' information, we will undermine our own efforts.

There are many unknowns to the City's proposed contact tracing system. We don't know who will have access to the collected data, how the data will be stored, or even how exactly the data will be used. Tracking systems inherently introduce privacy concerns given the sensitivity of health and location data. The government's limited emphasis on contact tracing to date has contributed to uncertainty about how privacy issues will be handled.

These privacy concerns are particularly acute given the nebulous role of private philanthropies in driving the City's tracing effort. Mayor de Blasio has said the City is working closely with the Johns Hopkins University and Bloomberg Philanthropies, but he hasn't provided details on what exact role these organizations will play and what control they'll have over resulting data. Alarmingly, one thing we do know is that Mayor de Blasio put New York City Health and Hospitals Corporation, an agency with no contact tracing experience, at the helm of the City's Test and Trace Corps.

To succeed, the Test and Trace Corps must actively engage with all New Yorkers, making its operations and strategy completely transparent to the public. If contact tracing operates without proper safeguards and oversight, it will not only endanger New Yorkers' fundamental rights,[2] it will undermine the public trust that is indispensable to robust participation. Contact tracing is only effective when every member of our community feels safe providing the most intimate health information to contact tracers, but the de Blasio administration isn't doing enough to provide New Yorkers that safety.

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[1] Press Release: *Test and Trace: Mayor de Blasio Announces New York City Test and Trace Corps*, OFFICE OF THE MAYOR (May 8, 2020), https://www1.nyc.gov/office-of-the-mayor/news/333-20/test-trace-mayor-de-blasio-new-york-city-test-trace-corps.

[2] *See* Peter Swire, *Security, Privacy and the Coronavirus: Lessons From 9/11,* LAWFARE BLOG (Mar. 24, 2020), https://www.lawfareblog.com/security-privacy-and-coronavirus-lessons-911; *See generally* THE COLOR OF SURVEILLANCE CONFERENCE SERIES, GEORGETOWN LAW CTR. ON PRIVACY & TECH., (2019), https://www.law.georgetown.edu/privacy-technology-center/events/color-of-surveillance-2019/.

## 2. Data Protection

For contact tracing to succeed, New Yorkers need to know how our data will be stored, shared and analyzed. The Test and Trace Corps must provide a comprehensive plan for the full lifecycle of data management, including data deletion.

The City must be intentional about how it relies on technology as part of this tracing effort. Numerous for-profit technology firms are trying to convince New York and other jurisdictions that their technology is the answer, despite the fact that they often have no evidence to support the claim that their systems work. Even using a manual contact tracing model, where contact tracers reach out to patients from a call center, the City will still rely on technology to aggregate the database of contacts.

Mayor de Blasio indicated that the City would use Salesforce for this database effort,[3] creating a case management system, [4] enabling city officials to monitor the spread of the disease.[5] While it's helpful to know the name of the City's proposed vendor, that is simply not enough. The public needs to know who will own the data, who will have access, and whether any supposedly anonymized/aggregated data will leave the City's control.

We also have limited information about exactly what data the City plans to collect. In designing the contact tracing system, we must balance the need for accurate tracing against the risks of collecting too much. Excessive data collection will put New Yorkers at risk while creating a tempting target for everyone from ICE to hackers. Not only must we limit the amount of data collected, but we also need to limit the duration it's held. Unless we delete contact tracing data promptly, the pool of personal information will only grow, and with it, the danger to New Yorkers.

Sadly, there is no guarantee that New York's manual contact tracing won't grow to include new, invasive technologies. We expected that City officials will be inundated with requests from technology vendors who will make outlandish claims about the benefits of their products. Already, at least one Health Department official has raised the possibility of a smartphone app to report COVID-19 symptoms.[6] Additionally, City officials have indicated that call center tracers may also use automatic texting systems to monitor quarantine compliance.

## 3. Manual Contact Tracing Best Practices

Manual contact tracing will require City officials to thoughtfully evaluate precisely what data to collect. As tracers are potentially tasked with collecting New Yorkers' names, phone numbers, location history, health insurance data, financial data, and other data points, it is easy to be over-

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[3] Transcript: *Mayor de Blasio Holds Media Availability*, OFFICE OF THE MAYOR (May 8, 2020), https://www1.nyc.gov/office-of-the-mayor/news/330-20/transcript-mayor-de-blasio-holds-media-availability.

[4] *See* Elizabeth Kim, *Coronavirus Updates: A 5-Year-Old In NYC Has Died From A Condition Related To COVID-19*, GOTHAMIST (May 8, 2020), https://gothamist.com/news/coronavirus-updates-may-8.

[5] *See* Noah Higgins-Dunn and William Feuer, *New York City Partners with Salesforce on Coronavirus Contact Tracing Program, Mayor Says*, CNBC (May 8, 2020), https://www.cnbc.com/2020/05/08/new-york-city-partners-with-salesforce-on-coronavirus-contact-tracing-program-mayor-says.html.

[6] Hansi Lo Wang, *Wanted In New York: Thousands Of COVID-19 Contact Tracers*, NPR (May 8, 2020), https://www.npr.org/sections/coronavirus-live-updates/2020/05/08/852123327/wanted-in-new-york-thousands-of-covid-19-contact-tracers.

inclusive. All too often, New York has taken a "data maximalist" position, collecting as much information on residents as possible, but only later deciding if the information was truly needed. Such an approach is not acceptable for contact tracing.

We must also ensure that there is adequate screening of those who will be entrusted with these intimate portraits of our lives. As of Monday, the City has already conducted 800 initial interviews, and officials are looking to increase the pace of recruitment.[7] But in the rush to start our tracing efforts, the City must ensure that those hired to trace our movements are deserving of our trust.

In addition to adequate background checks, we need to implement data access controls and audits to ensure that contact tracers are only using their databases for the public good. It's too easy to imagine contact tracers abusing the tools they've been given access to, tracking the movements of a disgruntled neighbor, an estranged spouse, or even children. Proper access controls and auditing will build the level of trust needed to guarantee that New Yorkers will take part in the process.

Beyond creating privacy safeguards, the City must clearly explain the steps it's taking to the public. Many New Yorkers are deeply skeptical of sharing their health data, their movements, and their personal interactions with a complete stranger. For this reason, privacy safeguards aren't in tension with effective contact tracing, they are indispensable to its operations.

**4. Contact Tracing Coordination**

For decades, the Department of Health and Mental Hygiene has run a well-respected and effective contact tracing system, deploying culturally competent contact tracers who mirror the diversity of the city they serve. Like many organizations, we were surprised and saddened to see the Mayor ignore the Department's unparalleled experience to place the Health and Hospitals Corporation in charge.

The effectiveness of any contact tracing system depends on widespread support, and public health only works when the public trusts the public health system. But rather than actively reassuring New York's most vulnerable and potentially reluctant residents, the City's leaders are withholding the details. If the public is unwilling to hand over intimate information about their lives and health, contact tracing will hit a dead end. Our ability to track disease is only as strong as the public's ability to help.

New Yorkers also need greater clarity on how New York City's contact tracing efforts will be coordinated with State and regional efforts. With so many essential workers commuting in and out of New York each day, it's clear that contacts won't stop at the City's edge. Given the removal of the Health Department from this effort, and the loss of their unique contact tracing experience, it's unclear what benefit the City derives from operating a separate, parallel tracing system.

**5. Contact Tracing Equity**

If it is done well, contact tracing has the potential to narrow the grotesque inequalities that have defined the COVID-19 pandemic for our city. But if it is done poorly, contact tracing will only

[7] Sally Goldenberg, *Contact Tracing Leadership Change Costing City Delays, Say Involved Parties*, POLITICO (May 12, 2020), https://www.politico.com/states/new-york/albany/story/2020/05/12/contact-tracing-leadership-change-costing-city-delays-say-involved-parties-1283485.

exacerbate the factors that have taken such an outsized toll on New Yorkers of color and low-income communities.

That is why the City must ensure Test and Trace deploys a culturally and linguistically competent team of tracers who can reach all New Yorkers. At a time when low income New Yorkers,[8] Immigrants,[9] and people of color are both more likely to be essential workers[10] and to have limited access to health care,[11] these communities cannot be inaccessible to contact tracers.

The City should prioritize the hiring of trusted community messengers to reach these communities and educate New Yorkers about our tracing effort. The risk isn't merely that we'll overlook pockets of infection, but that our contact tracing data will systematically distort our vision of the facts on the group.

This is especially dangerous as contact tracing data informs the City's broader efforts to combat COVID-19. In the age of data-driven decision making, it's easy for officials to claim that policies simply are responding to the number. But data about and collected by human beings is almost inevitably biased, warped by the subjectivity that goes into creating a data set. As we look to contact tracing for a map of the disease, structural bias and accessibility barriers could easily blind us to many of those communities most impacted by COVID-19.

**6. Institutional data sharing**

Just as it's vital we protect against contact tracers' misuse of New Yorkers' data, we also need to ensure that no other entity be given access. This danger is most acute for the New York City Police Department (NYPD), which has already played an outsized and destructive role in our City's response to COVID-19. There must be absolutely no circumstances under which police are allowed access to any form of contact tracing data, including supposedly de-anonymized and aggregated information. Any information flow the NYPD whatsoever will chill public engagement, accelerate the spread of COVID-19, and put historically over-policed communities at extreme risk.

Already, we've seen the Police Department use social distancing enforcement to transform a public health crisis into a pipeline for profiling and police misconduct. It is not enough to simply impose restrictions on those who hold contact tracing data, but we must fully understand what role the NYPD is playing in monitoring the spread of COVID-19. That is why I'm renewing my call for enactment of the only bill to comprehensively regulate the NYPD surveillance regime: The Public Oversight of Surveillance Technology ("POST") Act. The POST Act addresses the long-unmet need

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[8] *See* Connor Maxwell, *Coronavirus Compounds Inequality and Endangers Communities of Color*, CTR. FOR AM. PROGRESS (Mar. 27, 2020), https://www.americanprogress.org/issues/race/news/2020/03/27/482337/coronavirus-compounds-inequality-endangers-communities-color/.

[9] *See* Emma Goldberg, *When Coronavirus Gets Lost in Translation*, N.Y. TIMES (Apr. 17, 2020), https://www.nytimes.com/2020/04/17/health/covid-coronavirus-medical-translators.html; Allyssa M.G. Scheyer, *We Are Killing Them: The Heavy Toll COVID-19 Takes on Undocumented Immigrants*, JURIST (Apr. 22, 2020), https://www.jurist.org/commentary/2020/04/allyssa-scheyer-covid19-undocumented-immigrants/.

[10] *See* Richard Florida, *The Coronavirus Class Divide in Cities*, CITYLAB (Apr. 7, 2020), https://www.citylab.com/equity/2020/04/coronavirus-risk-jobs-essential-workers-data-class-divide/609529/

[11] *See* Cynthia D. Perry and Linda L. Blumberg, *A New Safety Net for Low-Income Families*, URB. INST. (2008), https://www.urban.org/sites/default/files/publication/33051/411717-Health-Insurance-for-Low-Income-Working-Families-Summary.PDF.

for civilian oversight of NYPD surveillance practices, particularly the acquisition and deployment of novel, highly invasive technologies. For years, the NYPD has built up an arsenal of spy tools on the public tab while trying to block public notice and debate. These tools include items like facial recognition, IMSI catchers (so-called "stingrays"), and automated license plate readers that can monitor a vehicle's location throughout the City.

These tools pose a privacy threat to all of us, but they pose a particularly potent threat to members of our immigrant communities. All too often, these systems create a risk of information-sharing with federal agencies, including ICE.

The evidence is clear: civilian oversight of surveillance enhances the public's trust in police departments and is absolutely necessary for public safety. Now more than ever, New York City must ensure it has appropriate safeguards in place to provide security to the public and to earn the trust that is critical to the success of any contact tracing effort.

**Community Health Care Association of New York State Written Testimony**
**NYC Committees on Health and Hospitals:**
**NYC's Plan for COVID-19 Testing and Contact Tracing**
**May 15, 2020**

The Community Health Care Association of New York State (CHCANYS) thanks the NYC Council for their attention to critical issues surrounding the response to the novel coronavirus (COVID-19) pandemic. On behalf of the more than 1.4 million patients that our members serve at 486 sites throughout New York City, we submit this written testimony to the joint Committees on Health and Hospitals.

New York City is undertaking an ambitious effort to conduct widespread coordinated COVID-19 testing and contact tracing response. To be successful, the City can leverage the capabilities and exisiting community trust maintained by the long-standing network of community health centers (CHCs), also known as federally qualified health centers (FQHCs).

Located in low-income, ethnically diverse communities, CHCs have a documented history of providing high quality and effective primary care to anyone who requires services, regardless of insurance status, immigration status, or ability to pay. In NYC, 16% of CHC patients are uninsured, 62% are enrolled in Medicaid or CHIP, 76% identify as black or Hispanic, or Latinx, and 35% are best served in a language other than English. Each CHC Board of Directors is comprised of a majority of CHC consumers, making CHCs well equipped to identify and prioritize the unique needs of the communities they serve. Early data shows that COVID-19 disproportionately impacts low-income communities, communities of color, and people with comorbidities; these are the very communities CHCs have served since the 1960s. For these reasons, CHCs are the ideal partner to collaborate with the City in its effort to test and treat people in the communities most adversely impacted by COVID-19.

CHCs are well versed in mobile care, street medicine, and team-based care, all of which could be leveraged for wide scale testing and tracing. Also, CHCs employ promotoras and community health workers who are from the community and uniquely understand the concerns and needs of their patients. These individuals would be ideal candidates to partner with contact tracers if properly trained and supported by City infrastructure. CHCs' history of being embedded in their communities undoubtedly make them a key resource in the provision of COVID-19 testing, tracing, and treatment in underserved communities.

CHCs are ready and eager to engage in COVID-19 testing. However, current NYC Department of Health and Mental Hygiene (DOHMH) guidance directs outpatient clinics (like CHCs) not to conduct COVID-19 tests with the explicit goal of conserving personal protective equipment (PPE).[1] Assuming this guidance is clarified to acknowledge that PPE is available and that testing may be conducted in outpatient settings, there are many ways that CHCs could partner with other entities and become integrated in the efforts to test and trace for COVID-19. For example:

[1] https://www1.nyc.gov/assets/doh/downloads/pdf/han/advisory/2020/covid-19-03202020.pdf

New York City Office 111 Broadway, Suite 1402, New York, New York 10006 T 212-279-9686 F 212-279-3851
Albany Office 90 State Street, Suite 600, Albany, New York 12207 T 518-434-0767 F 518-434-1114

**Testing**

- Conducting COVID-19 testing at CHC sites or at the site of a partner organization
- Communicating positive COVID-19 results to patients' primary care physicians

**Supporting Contact Tracers**

- Initiating contact investigation by educating patients regarding the contact tracing process at the time of test specimen collection
- Interviewing patient and/or family members, if patient is unable to be interviewed, to collect history of patient's activities throughout the potential incubation period and create the framework for identifying all potentially exposed individuals, including where contact tracing should focus
- Providing follow up testing and care to individuals identified as potential contacts by contact tracing
- Informing individuals of recommendations or requirements regarding testing, quarantine, and monitoring
- In the absence of a designated primary care provider, helping individuals who have tested positive or been identified by contact tracers as potential positives to establish a medical home
- Communicating with City government throughout the process to ensure accurate and timely data is available for public health decision making

Undoubtedly, a coordinated effort requires coordinated investment. Clear guidance and protocols must be available to all partners engaged in contact tracing and testing. The City also must ensure that providers participating in testing and tracing are adequately trained, equipped, and funded. The City should make funds available to cover technology needs, reimburse for staff time, and ensure adequate sourcing and distribution of PPE.

Without a coordinated response that leverages the resources of all health care and social services partners, including CHCs, New Yorkers in underserved communities will continue to be disproportionately affected by COVID-19. CHCANYS remains available to prevent these communities from suffering further.

**COVID-19 Community Outreach Worker Concept**
City Council District Pilot
14 May 20
Kellie Leeson – Constituent City Council District 2

**Background:**
New Yorkers came together at great personal cost to heed the call to "flatten the curve". Those who could stay home did so. New Yorkers quickly sheltered in place, respected social distancing, and began wearing masks. Essential workers from across the city continued to provide critical medical care and basic services to treat patients and prevent new ones. New hospitalization rates in the state remain stubbornly over 500 admissions a day and the death toll is nearing 15,000 people. The NY PAUSE guidance remains in place until May 15th.[1] Currently, all New Yorkers are required to wear a mask or face covering when out in public and in situations where a 6-foot distance from others cannot be maintained.[2]

While great gains have been made in controlling Covid-19, and building city capacity and treatment knowledge, exposure to the disease remains a risk to all New Yorkers. Reporting indicates that an effective vaccine remains at least 18 months away. As the summer months approach, New Yorkers, tired of being stuck indoors will flock to streets and parks for fresh air, connection and activity. Keeping in mind Covid-19 prevention measures, this behavior should be encouraged, for both the physical and mental health of New Yorkers.[3] The message since the start of the Covid-19 pandemic has been that we are all in this together, NYC should continue to build on the spirit of mutual support. Informed estimates indicate that the COVID pandemic will be a part of our daily reality for the next 2-3 years, as such, we need to plan now to communicate and support appropriate social distancing measures for the long term and help New Yorkers to understand and mitigate risk.[4]

Unfortunately, more recent events have highlighted unequal enforcement of social distancing and mask compliance, situations that may quickly undermine the efforts to maintain mass adherence.[5] As indicated in the recent Johns Hopkins Report, *Public Health Principles for a Phased Reopening During COVID-19: Guidance for Governors,* Covid-19 is a public health issue that needs community engagement to build trust and ultimately long term compliance.[6] And the most recent CIDRAP newsletter helpfully highlights the importance of engaging the public for their own action noting, "Even better than prescribing actions for people to take is offering them a menu of actions. This recruits not just our ability to act, but also our ability to decide. The opportunity to choose ways to protect ourselves and ways to help our neighbors gives us a much-needed sense of control in this out-of-control time."[7] Most recently, the Mayor has announced that he is deploying Social Distancing "Ambassadors" in communities to reinforce social distancing rules. This is a great development and should be encouraged and supported with additional community engagement to reinforce the messaging of these ambassadors. [8]

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[1] https://twitter.com/NYGovCuomo/status/1259514744953663488
[2] https://portal.311.nyc.gov/article/?kanumber=KA-03303
[3] https://www.cdc.gov/coronavirus/2019-ncov/daily-life-coping/visitors.html
[4] https://www.theatlantic.com/ideas/archive/2020/05/quarantine-fatigue-real-and-shaming-people-wont-help/611482/
[5] https://gothamist.com/news/de-blasio-shrugs-leaked-data-showing-massive-racial-disparities-nypds-social-distancing-arrests
[6] https://www.centerforhealthsecurity.org/our-work/pubs_archive/pubs-pdfs/2020/200417-reopening-guidance-governors.pdf
[7] https://www.cidrap.umn.edu/sites/default/files/public/downloads/cidrap-covid19-viewpoint-part2.pdf
[8] https://nypost.com/2020/05/10/nyc-to-use-2300-social-distancing-ambassadors-amid-tension-with-cops/

While the "flatten the curve" message was easily and quickly understood, the messages around social distancing and consistent use of masks has been less consistent leaving New Yorkers unclear about the details of the guidelines and rules surrounding these two issues.[9]

With the goal of ensuring long term adherence to mask and social distancing measures, this program will utilize well established principles and practices of community engagement to build public awareness of the key agreed messages and guidance, educate the public on these interventions and build peer acceptance of Covid-19 prevention measures rather than depend on draconian "enforcement" measures that will lead to resentment and frustration.[10][11]

**Program pilot concept:**
Covid-19 is a public crisis in need of public health interventions including clear information to educate the public about the disease, associated risks, and the public's role in preventing the spread of Covid-19.

This pilot program would target city council district xx with a community outreach program to build public trust, support community revitalization and ultimately prevent Covid-19 transmission. This pilot program will focus on hiring recently unemployed community members and young people as community outreach workers. These community workers will be trained as educators and influencers to communicate basic and accurate public health messages relating to Covid 19 including symptoms, prevention, and access to health and human services to their neighbors. Building on existing knowledge infrastructure, two part-time outreach workers will be assigned to xxx blocks as their "turf". Their role will serve as a vital interlocuter between the community and critical resources through the city council office and other social services. These Workers would The Outreach Workers will get to know their neighbors by providing building to building information, provide wellness checks over phone and text, and link residents with social services including food distribution programs in their assigned area. The Outreach Workers will also identify opportunities for low tech messaging in areas of congregation and foot traffic. The LinkNYC kiosks provide excellent messaging while posters, banners, etc, can be employed to encourage social distancing and mask compliance in areas not reached by LinkNYC. Lastly, Outreach Workers will be asked to use their social media network to distribute messages.

Building a boat in the middle of a flood is not ideal so rather than starting from scratch these community workers will build on and engage with existing community groups and structures such as tenant associations, community groups and associations, resident watch groups and connect with the existing neighborhood coordination officers, where and when appropriate. Relationships with existing groups will allow for trust to create two-way communication with the most up to date developments in Covid-19 information as the situation will evolve in Covid-19 prevention efforts. In addition, once the contract tracing program is established, the community outreach workers with their intimate neighborhood knowledge will be a vital link to the tracing and tracking program.

This project can be quickly supported through small grants to existing community groups interested in participating. An initial cohort of 50 Community Outreach Workers could be recruited and supported through this existing infrastructure with deep knowledge of the community and experience supervising community activities. This initial cohort will receive xx hours of training following WHO community

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[9] https://www.gothamgazette.com/city/9387-summonses-arrests-social-distancing-violations-nypd-de-blasio-coronavirus
[10] https://cchealth.org/public-health/pdf/community_engagement_in_ph.pdf
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engagement guidelines[12] on the basics of community communications, public health messaging, Covid-19 prevention and referrals. This training will be developed in coordination with the City's Department of Health and Mental Hygiene office.

| **Vision:** | **The people of NYC are healthy, safe and informed** |
|---|---|
| **Goal:** | **xx% of people wear masks outdoors** |
| | **xx% of people maintain social distance while in stores, parks and any area where sustained (more than xx minutes) interaction takes place** |
| **Primary Objectives:** | To educate the community on public health risks of Covid-19 |
| | To inform the community where and how to access health, food, and housing services and resources including links to contact tracing |
| | To provide community members with basic protective goods - masks, hand sanitizer, soap and gloves |
| | To support and develop compliance to public health measures (social distancing and masks), especially among the youth |
| | To provide jobs to the recently unemployed and young people |
| **Secondary Objectives:** | To reduce the risk of unnecessary interactions between the police and community members |
| | To build community outreach infrastructure |
| **Considerations:** | While the NYPD may provide safety for some segments of the population, risk can be created for others. |
| | NYPD members have stated that they should not be involved in social distancing enforcement.[13] |
| | Using a public health outreach approach relies on building compliance through knowledge and community trust and recognizes that some members of the community will not comply. This will be a small minority and the risk is understood. |
| **Assumptions:** | Short term strict enforcement of social distancing and mask compliance will undermine long term adherence and overall public health. |
| | Youth programming resources will be available (reinstated) that can be repurposed to support his program. |
| | The city council district xx has existing relationships with community groups that could be expanded to include support to Community Outreach Workers. The "Ambassadors" program will be an additional information resource. |
| | Public health communications are critical to effective public health interventions and thus far these messages have been confusing, contradictory and weak in NYC. |
| | District maps and household information is readily available through each city council office and all campaign offices. |

*City Council District x Overlaps with:*
Assembly districts – xx
Senate districts – xx
Community boards – xx
NYPD precincts – xx

[12] https://www.who.int/publications-detail/risk-communication-and-community-engagement-readiness-and-initial-response-for-novel-coronaviruses-(-ncov)
[13] https://news.yahoo.com/nyc-police-union-claims-city-180811992.html

To Whom It May Concern:

As a public school guidance counselor, parent of two children, and proud New Yorker who wants our mayor to put health and science before political in-fighting, I am deeply opposed to the mayor's decision to remove contact tracing from the control of the NYC Dept of Health. **The City Council must pressure the mayor to restore contact tracing to the Dept of Health, NOT NYC Health & Hospitals.** It is clearly a political move based on mayor DiBlasio's wounded ego from the Dept of Health pressuring him to do his job and close the city, a decision which he dragged his feet on unnecessarily and we are all now paying the price in record Covid cases.

We have one of the best health departments in the country, and even in the world, and they are experts and veterans at contact tracing and infectious diseases. The head of the Hospitals is not well-equipped to handle contact tracing and has very little experience. We do not have time to learn this on the fly, there is too much at stake, and you will lose valuable time, resources, and NYC's long term economic stability depends on effective contact tracing.

DiBlasio likes to lambast Trump but this move of his is ironically Trumpian – it is ego-driven, a personal power move, and a selfish move.

Mayor DiBlasio, please put our city's health before your personal ego, swallow your embarrassment, and do the right thing. Put contact tracing back in the hands of the Department of Health.

Sincerely,

Jon Alvarez
299 13th St Apt 3C
Brooklyn NY 1215

**Testimony from Anthony Feliciano, Director Commission on the Public's Health System**

**Committee on Hospitals -REMOTE HEARING - Oversight: - NYC's Plan for COVID-19 Testing and Contact Tracing. T2020-6166 Jointly with the Committee on Health**

**May 15, 2020**

I like to thank Council Woman Carlina Rivera and Councilman Mark Levine and members of the Hospitals Committee and Health Committee, and Speaker Corey Johnson for this oversight hearing today on- NYC's Plan for COVID-19 Testing and Contact Tracing.

The COVID-19 virus does not discriminate — it can infect anyone. However, when an indiscriminate virus is unleashed in a country and in a city as ours, where racially unjust systems have long decided who lives, who dies, who thrives and who just gets by, the impact is anything but equal. Immigrants, people of color and other marginalized communities have been hardest hit. The inequities and the disparities in the health and well-being of our communities must act as another catalyst to change the picture.

We had an inadequate health care response partly to do with to ill-policies and over 20 years of hospital closings approved by the State Department of Health--primarily impacting low-income communities of color.

The COVID-19 crisis has touched all aspects of infrastructure and economic activity in New York City, but it has not affected all New Yorkers proportionately. Frontline food service, grocery store, and health care workers are disproportionally people of color, immigrants, and uninsured. This segment of the work force has allowed most New York residents to stay at home, helping to flatten the curve of new infections. It is not an exaggeration to say that low-income New Yorkers have saved thousands of their neighbors' lives by allowing them to shelter in place. As we move forward in restarting the economy, it will be necessary to remind decisionmakers that low income workers are protagonists in the city and the state's recovery

According to a new study, "3.7 million frontline health workers have medical problems that raise their risk of dying from COVID-19. Many health care workers lack insurance and paid sick

leave, more than 600,000 live in poverty. More than a quarter (26.6%) of America's nearly 14 million patient-contact health personnel are at risk of severe illness or death from COVID-19 because of age or chronic conditions, Researchers also reported high rates of un-insurance and poverty among frontline health workers, who are likely to be exposed to COVID-19 at work".

The study in the Annals of Internal Medicine was conducted by researchers at the City University of New York (CUNY) at Hunter College and Harvard Medical School. While the they analyzed data from two national surveys of thousands of health workers, we can infer that the problem is also being faced by vulnerable workers in NYC- workers who are from immigrant and communities of color.

The study added the issues of millions of Americans whose health care jobs bring them into direct contact with patients that have medical conditions like diabetes or heart disease that put them at high risk of death if they contract COVID-19. The study also found that 28.6% of all patient-contact personnel lack paid sick leave, including 1.12 million of those with underlying health problems. About 275,000 health care workers with high-risk conditions are also uninsured, including 11.4% of those with diabetes, and 20.8% of those with chronic lung disease.

In early April, the entire nation watched in horror as New York City hospitals like H+H Elmhurst were deluged by patients with COVID-19 in respiratory distress. We have more than 34% of New York City deaths due to COVID-19 are among Latinx populations, although Latino individuals only make up 29% of the city's population. Similarly, 28% of New York City deaths were among black New Yorkers, even as they only make up 22% of the city's population. The Fiscal Policy Institute (FPI) has noted that New York City has one million individuals that fall under the umbrella of essential worker. More than half essential workers in the city were born in another country, and a third of these workers are black.

We are concerned that undocumented immigrant patients and communities may not know that Emergency Medicaid will cover for testing and treatment. As New York starts to take steps to re-open, and workers struggle to make decisions about whether they can safely go back to work, clear information about all these considerations will ease uncertainly. Community-based organizations will need to be engaged in sharing information with their clients and the communities they serve.

We identify three major areas of concern from our coalition work as it relates to testing especially for immigrant, communities of color, and people with disabilities. They are:

**Access to testing**

- the geography of test sites and whether the test is walk-up or drive through.
- whether sites are in or near communities of color; We do commend the recent testing sites that have opened at several the NYC Health + Hospitals facilities. But this was not the case before and with fears of public charge and other barriers, we need to consider other safe spaces.
- the reality that many individuals do not have a primary doctor that can refer them for a test. We don't have percentages of who have been having this challenge but we know there is close to 600,000 New Yorkers who don't have any type of health coverage and we have medically underserved neighborhoods where there is a lack of primary care doctors.
- whether accessing a free test through a doctor's office will involve the cost of an office visit; and
- what reassurances patients and communities have that they will be able to afford treatment.

**Behavioral dimensions to testing include:**

- complexity of results and what they mean for avoiding future transmission (e.g. a negative antibody test does not mean immunity); and
- the emotional impact of receiving a positive test, especially for individuals with chronic or life-threatening diseases and from immigrant and communities of color that have stigmas around diseases and infections.

**Social Determinants of testing:**

As new testing capacity is created, for communities who have been decimated, immediate and accessible access to information about it will be critical. The broader testing shortage and the need to discourage people from overwhelming health care facilities has meant that ongoing information about existing testing resources is difficult to access. Information needs include:

- the difference between viral and antibody testing,
- who can benefit the most from which test,
- the utility of testing for people concerned that they are asymptomatic carriers, and
- shifts in prioritization for who may request a test.

In addition, we and other New York City Community groups, with long and outstanding records of undertaking health initiatives in COVID-impacted communities are extremely dismayed at the announced state contact tracing plan which would be largely administered through Bloomberg Philanthropies--- and entirely excludes community partnership and participation. In the areas of tracing, some of the same issues, I spoke about testing applies.

We were invited to the first meeting of the Department of Health Community Advisory Group for Testing and Tracing. We believe at least as it has been presented that there is an understanding of placing an equity lens to COVID testing and tracing- but action will inform us if achieves successful implementation of tracing and with a lens on equity. These are some important elements we would like the city council to look out for:

- Launching of hiring and training of tracers from the city. There is a history both of major errors but also phenomenally successful efforts of contact tracing in exceedingly difficult situations, from TB to HIV/AIDS to Hepatitis. We only have weeks to get this up. Quick hiring should not be at the expense of in-depth training including on Bias awareness and making sure we have the right people who have the right skills does not always mean people with bachelors or masters degree, and most importantly people that can demonstrate patience and empathy to listen. Other states have Contact tracing and debt collection require the exact same skills. While that may have some truth, it is not what we want. Debt collectors in health care are not sensitive nor culturally competent.

- Locating patients and contacts who may be difficult to reach or reluctant to engage in conversation. Strangers calling, especially immigrants who already fear government and accessing services due to federal government attacks and public charge. No one should feel they can't get tested or avoid a tracing call due to fear doing so would lead to deportation.

- Rising eagerness for automated technology as a key for infection control. There are serious concerns that voluntary, anonymous contact tracing through smartphone apps—.will serve as vehicles for abuse and disinformation. They could potentially provide a

false sense of security to justify reopening our economy, well before it is safe to do so. In addition, we have a digital divide and denied.

- Policy of quarantine and congruency with those decisions. We cannot violate people's right, and quarantine measures have a history in our country to disproportionately harm communities of color. This tool has been around for centuries and are usually of limited utility for highly transmissible diseases, and if imposed with too heavy a hand, or in too haphazard a manner, they can be counterproductive.

**Therefore, we ask and reinforce the following in Tracing and Testing:**

- Demand all appointed committees and taskforces are led by those impacted. To ensure those taskforces facilitate community input beyond placation. We and our fellow community-based organizations have experience in the past that we are invited to spaces to respond to ideas versus co-designing.

- As contact tracing and isolation are expanded, public health personnel will need to counter stigma and fearfulness with positive messaging affirming contributions to the public's health. Among communities who have been subject to medical procedures without consent, or had trust violated through unethical research, the proposition of being forcibly quarantined may be especially suspect. The experience of immigrant communities during the TB epidemic in the 1990's and of generations of multiple communities with HIV testing may complicate efforts to reach everyone equally. Efforts to support individuals to self-isolate in their home or a location of their choosing will be more successful than restrictive or punitive measures.

- Local trust, peer engagement and community knowledge and participation be part of the planning and implementation

- The City Council to join us to call for more transparency in the planning and in demanding that Bloomberg Philanthropies immediate partner with community groups and the formation of a Community Advisory Board to review and advise on New York COVID-19 contract tracing

- Enough tests for all NYC residents must become available, it will be critical for public health personnel to employ a social determinants of health framework to testing, basing intervention on systems and contact exposure and not profiling people of particular job types. Tests must be available during evenings and on weekends. Compliance with the city's sick leave policy will need to be enforced, and individuals with positive tests must receive documentation from the city validating their need to stay home and self-isolate.

- Acute need for a multi-agency advisory group composed of people from many affected communities in the city to learn more about how to reach communities and develop best practices for outreach, testing, and emergent issues. Although we know that the DOHMH has convened an Emergency Partner Engagement Council, we believe there is a need for a broader empowered body that makes recommendations to the city on access and response issues.

- Address the following types of information every time that information is disseminated:
    - ✓ Have you addressed language access?
    - ✓ Have you provided information on insurance, including emergency Medicaid?
    - ✓ Have you addressed chronic disease and disability?
    - ✓ Have you engaged community-based organizations that work with immigrant, communities of color and other vulnerable populations in the creation and distribution of this document?

- Ensure anonymity as a critical component to the tracing protocols. Contact tracing must be balanced with maintenance of trust with vulnerable communities and sensitivity to individual situations  This is why groups are demanding that Bloomberg Philanthropies immediate partner with community groups and the formation of a Community Advisory Board to review and advise on New York COVID-19 contract tracing.

- Aim at reducing the harm of a technological intervention that seems increasingly inevitable

- Protect people from surprise medical bills for any testing and treatment.

- Improve the Data collection of race, ethnicity, disability, and other demographics through better aggregation so resources can be targeted.

- Spur a fiscal environment that supports "essential workers". We need a city budget that recognizes this and protect vital health services and programs, education, housing, and other key immediate needs. We would think the Mayor would not follow the same path of the Governor with devastating cuts. He has choice.

- Reassess NYC Thrive program to ensure it is addressing the stressors, mental health needs, post-traumatic stress that has been exacerbated by the pandemic.

Thank you

Anthony Feliciano * Director, CPHS * afeliciano@cphsnyc.org * 646-325-5317

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Op-ed

https://citylimits.org/2020/05/11/opinion-correcting-nycs-health-disparities-starts-with-how-we-do-contact-tracing/

Opinion: Correcting NYC's Health Disparities Starts With How We Do Contact Tracing

AUTHOR

Judy Wessler and Anthony Feliciano

Date 5/11/2020

We are living through a horror in New York State and City. There were warnings that were unheeded of a pandemic that would hit our shores. Did we get prepared? No. Instead over the years, particularly in the city, a once proud and forward thinking and planning public health department lost staff and resources.

Despite these losses, the city health department has done an important job of documenting health, social data and other characteristics in the city's community districts. The disparities and racism (both official and institutional) are clear and outrageous. This has been the case for an exceptionally long time and is the result of thousands of decisions made by local, state, and federal authorities, in both the public and private sectors. Indeed, it is not that difficult to determine the neighborhoods that are most at risk in daily life, and more so when a scourge such as COVID-19 is introduced into the mix.

The other undeniable truth in our diverse city of neighborhoods is that one-size message does not fit all. Social distancing is often not necessarily possible in many communities, especially if it is only spoken in one language.

In addition to losses in the public health infrastructure, a state plan to limit the number of hospitals and hospital beds over the years has contributed to the unfortunate picture in low-income, immigrant, and communities of color. Documentation of the impact of hospital closings in medically underserved communities of color has not slowed this phenomenon. The encouraged consolidations of community institutions into large, powerful networks of hospitals, has deepened it. The public decision-making has

moved to healthcare network corporate boardrooms, eliminating any concern on the impact on the effected communities.

The COVID-19 crisis has touched all aspects of infrastructure and economic activity in New York City, but it has not affected all New Yorkers proportionately. Frontline food service, grocery store, and health care workers (i.e. home health aides and homecare workers) are disproportionately people of color, immigrants, uninsured and women. They have allowed most New York residents to stay at home, helping to flatten the curve of new infections. It is not an exaggeration to say that low-income New Yorkers have saved thousands of their neighbors' lives by allowing them to shelter in place. We also suspect that the unique reach and capacity of NYC Health + Hospitals may have played a role in saving the lives of low-income people on Medicaid and the uninsured that depend on it.

No one who is in the least familiar with neighborhoods in the city is surprised at how the virus started and has spread through the city. The underserved communities in Queens, Brooklyn, and the Bronx were first and hardest hit. Yes, the burden of underlying disease in these communities is high and unmistakable. But that is just a part of the reason for the spread of the disease. The vulnerability of the residents in these communities is very much attributable to the crowded living conditions because of very high rents, the lack of access to good food, the worry over money because salaries are so low, the stress of survival, and more. We used to call these factors "activities of daily living," but now we have a fancy name: "Social Determinants of Health."

The inequities in the healthcare system and the disparities in the health of our communities must act as a motivator to change the picture. But this will not happen unless our approach changes dramatically. We need to do things differently than we have in the past both to correct old wrongs and chart a path to avoid future errors.

The governor and mayor are starting on the best path to addressing the pandemic. Both are determined to have programs of testing and contact tracing underway and involved in the determination of how and when to reopen the state and city. This is the scientific and preferred way of making these decisions—so we applaud them for this effort.

Why is this approach wise? It's clearly important to know the extent of the disease in each community. There are many people who are asymptomatic, meaning they are not showing the symptoms of being ill, yet they are capable of spreading the virus. Knowing who fits in this category and having them isolated until they are cleared of the disease will have an immediate impact on stopping the spread. Knowing the count of illness in each community points the arrow at where resources are needed in order to make a difference. This information is needed to plan appropriately.

The focus during this pandemic has been on hospitals—a focus that was needed, at least initially, although the lack of testing equipment and the stringent criteria to be tested may have contributed to the very sick status of people being hospitalized and later dying. But COVID-19 is a disease and therefore fits into the category of a public health problem. The focus now must be on public health solutions. These are very different than medical solutions.

Through the Fund for Public Health, the city is hiring a thousand contact tracers who will follow up on positive results to reach the people that the infected person came in contact with. We are hearing that the criteria for these positions includes professional backgrounds. But is that necessarily the people who will gain entry and the trust of people in many immigrant and communities of color? No, probably not.

Public health dictates that the persons making the contact must be culturally competent, understand and speak the languages of the communities they are approaching. This is a sensitive endeavor and the persons up front must be trusted and understanding. The preferred way of doing this task, like most public health work, would be community-based organizations that are of, from, and trusted in their communities. This is what works and must be a critical part of what the city initiates. This has got to be the new normal and what the city, working with community organizations that know and understand this importance, must move toward quickly. Otherwise this initiative will be costly, not accomplish its goals in the effected communities, and fail to eliminate the spread in the communities most impacted by this disaster.

Do it right now and we will create a model for how to address not just this calamity but other public health concerns and the range of issues that impact our communities.

Judy Wessler is a longtime community health policy advocate. Anthony Feliciano is the director of the Commission on the Public' Health System.

Testimony regarding to New York City Autism Initiative
New York City Council Mental Health Committee
May 15, 2020

Agency: Commonpoint Queens (Formerly Samuel Field YM-YWHA, Inc. + Central Queens Y)
Agency Contact:Amanda Smith, LCSW, Senior Director Special Services,
ASmith@commonpointqueens.org, 718-225-6750 ext 286

On behalf of Commonpoint Queens and the families throughout all areas of Queens that we serve, I want to thank the New York City Council for their efforts in extending the reach of the city's service on behalf on children with Autism Spectrum Disorders. Together, we are addressing a serious public health challenge as Autism is a significant developmental disability that according to the CDC now impacts 1 in 68 children.

Through your support, during the during the 2019-2020 program year Commonpoint Queens will be able to include increased numbers of children in after school, socialization and recreational program. In fact, we anticipate that more than 100 children with Autism will be involved in our multifaceted program that includes daily after school programs and enrichment, social skills development sessions and the pride of our community, our specialized sports leagues.

New York City Council support, in my agency's case, is additive to the award that we were honored to receive from the spring 2016 RFP offered through DOHMH and originally administered through Public Health Solutions. Since our resulting award was significantly less than the Autism Initiative funding that the agency received in prior years through Council funding, your continued support has been critical in ensuring that Commonpoint Queens did not lose our ability to maintain and build the robust variety of wraparound services for children with Autism upon which families raising children with Autism in Queens depend. Without your support, we would have had to reduce our capacity by a staggering 33%.

You support enables parents raising children with Autism to receive much needed respite and to pursue employment outside their homes empowered with the knowledge that their child is being cared for in a safe, enriched environment; your support enables families to access social skills development sessions that would be extraordinarily expensive should families alone need to shoulder the burden for the specialized care; and significantly, your support enhances the quality of life for the full family when basketball and soccer leagues meet throughout the year in which the child with Autism is partnered with a specially trained community teen. Everyone wins in Basketball Buddies and Soccer Stars.

We recognize the power of culturally competent practice in meaningfully engaging families raising children with Autism to receive diagnosis and treatment, actively participate in programs, and to effectively advocate on behalf of their children. Reducing the stigma of Autism, disability and received help as essential elements in this process. At Commonpoint Queens, culturally competent practice is a standard for which we strive to consistently achieve. We believe that

activities that involve increased levels of community inclusion as well as promoting Autism awareness assists in facilitating a sense of belonging among the families that receive our services. At Commonpoint Queens, our population of children with Autism and their families reflect the heterogeneity that is the Borough of Queens  as does our staff, community teens that serve as individual coaches in our sports leagues as well as our diverse community partners that refer to us. We proudly serve children whose families speak English, Spanish, Chinese, Korean, Russian and Creole and involve families from more than 21 neighborhoods in the Borough.

Thank you for understanding that children with Autism and their families have the same needs, wants and desires as those children and families without Autism but face significant challenges in having their needs addressed. Thank you for making their path less complicated and for providing greater access to services.

hispanicfederation

**NATIONAL HEADQUARTERS**
55 Exchange Place, 5th FL
New York, NY 10005
Phone: 212.233.8955
Hotline: 1.866.HF.AYUDA

Testimony re: NYC's Plan for COVID-19 Testing and Contact Tracing
Submitted to
NYC Council, Committees on Health and Hospitals

Submitted by
Bethsy Morales-Reid
Senior Director for Health Initiatives
Hispanic Federation

May 15, 2020

Good Day. My name is Bethsy Morales-Reid and I am the Senior Director for Health Initiatives for Hispanic Federation. I would like to thank Chairwoman Rivera, Chairman Levine, and all committee members for bringing us together today to discuss the integral role testing and contact tracing has in the war against the virus SARS-CoV-2 in order to prevent the disease COVID-19. As is colloquially accepted, when discussing this issue further I will be using the term COVID-19 to refer to both the disease and virus.

Scientists and medical professionals have used testing and contact tracing to control infectious diseases for decades. This strategy was particularly impactful in the fight against Ebola. While quarantining was found to be effective in containing the disease, success was directly dependent on testing and contact tracing. Additionally, testing and contact tracing has been a pivotal approach to limit the spread of HIV by notifying partners of those who have tested positive and encouraging them to get tested as well.

Contact tracing coupled with testing is the most promising approach to identifying new infections and preventing further infection. There are two key elements to this strategy to make it successful: adequate testing and candid conversations with contact tracers. Those who are tested can begin treatment and isolation measures right away. Identifying COVID-19 positive individuals also helps to stop the spread by warning contacts of exposure. In comparison to many other countries around the world, testing in the United States has been insufficient for optimal early containment. In turn, we are seeing a rapid rise in hospitalizations that is overwhelming public health and clinical care systems. Accurate and timely testing must be made available to everyone, within their own communities, at places they know and trust, for these containment efforts to be successful.

The second key element is candid conversations with contact tracers. Contact tracers must be trusted by community-members in order to have effective conversations and receive thorough and accurate information. The current contact tracing system used in the United States involves individuals having conversations, either by phone or in-person, to collect names and contact

information of those who have come in contact with individuals who have tested positive. Community-members must have confidence that the information they provide to contact tracers is truly confidential. For this reason information collected through contact tracing must be strictly protected.

Communities of color have been disproportionately affected by this pandemic. Data from the New York City Department of Health shows that the virus is killing Latinos and Blacks in the five boroughs at twice the rate than it is killing Whites. Official public health data is just now accounting for the hundreds of men and women who have died of the disease in their homes. Indeed, when the worst of the crisis subsides we will find that significant numbers of Latino New Yorkers, especially those whose immigration status was unsettled, avoided hospitals out of fear of incurring costs of care or falling victim to the anti-immigrant enforcement actions of the Trump administration.

For contact tracing to work in communities of color across the city, community members must be able to trust and confide in contact tracers. When speaking with COVID-19 positive individuals, contact tracers are collecting the name and information of everyone that individual has come into contact with – potentially including undocumented relatives or friends illegally subletting apartments. To have effective, accurate and candid conversations with community members, contact tracers must have cultural and linguistic competency appropriate for the local community. For these reasons, it is imperative that contact tracers come directly from the communities they are working in. The community health worker model has been proven successful in health education because the community trusts peers, it is a lesson that has made many public health efforts successful.

Hispanic Federation's network of 150+ Latino community-based organizations, over 60 of which are located in New York City, are front-line service providers for our neighborhoods and communities. The work they are doing today – and are committed to doing over the coming weeks and months – will be essential for us to get through this public health crisis.

Our community has historically counted on community-based organizations for information and resources. If we are to effectively address this unprecedented crisis in Latino neighborhoods in NYC, we must make sure that Latino community-based organizations (CBO) are working hand in hand with any institution or agency leading this effort. Our nonprofits are deeply embedded in our neighborhoods, providing frontline health and human services to millions of Latino New Yorkers. Community members trust their CBOs, which have the unique ability to build essential bridges for the community. With deep roots in their communities, CBOs can assist with a multitude of aspects comprising a contact tracing program, such as disseminating information, employee recruitment, and the development of a culturally competent script for contact tracers.

Moreover, large-scale public education campaigns about contact tracing will be crucial to the program's effectiveness. Community members must have a basic knowledge of why contact tracing is important, why they should engage in conversation with contact tracers, and how to identify credible contact tracers. In order to have an effective wide-spread public education campaign that will reach communities of color, ethnic media partners must be engaged. Particularly in the Latino community, Spanish media is a highly trusted and reputable source of information and its success is based on its deep connection to community Spanish media must be activated to provide critical information to encourage community members to divulge necessary information to contact tracers. Ensuring that public education campaigns are created in a cultural and linguistic competent manner will positively impact the success testing and contact tracing.

Through community involvement and prioritizing dissemination of information through culturally and linguistically competent mediums, contact tracing will be successful in stopping the spread of COVID-19 and save lives. Thank you for your time. Hispanic Federation is here to serve and is happy to work with the New York City Council to protect all New Yorkers.

**Testimony of Henry Garrido, Executive Director, District Council 37**

**Health + Hospitals Contact Tracer Program**

Good morning, my name is Henry Garrido. I'm the Executive Director of District Council 37, New York City's largest municipal employee union, with over 150,000 members. I appear before you today to testify on the new Contact Tracers program to be rolled out by Health + Hospitals.

We are pleased to support the decision of H+H running the program and more supportive of the recent decision to hire hundreds, and potentially a thousand, new Public Health Advisers for the City's Contact Tracing program. This role couldn't be a more perfect fit for our members in this title. Public Health Advisers have been on the front lines of tracking and controlling the spread of diseases in New York City for decades, from typhoid to tuberculosis, from HIV to H1N1 influenza, from SARS to Ebola. They work hand in hand with Public Health Epidemiologists, Public Health Nurses, Public Health Sanitarians, and various health care providers across the City. They are instrumental in providing accurate and science-based information, advice, and referrals to the general public, as well as school and hospital staff.

NYC's public health soldiers have been pioneers in combatting outbreaks of communicable diseases. For example, the TB Bureau where some of our Public Health Advisers currently perform these functions, is one of the national leaders in public health testing and education. They were on the front lines during the resurgence of TB in the 1990s, particularly addressing multi-drug-resistant (MDR) strains of TB that arose seemingly out of nowhere. The full-court press by the TB Bureau involved hundreds of Public Health Advisers and Public Health Assistants visiting individuals with TB and their contacts in their homes.

The mission of the Public Health Adviser is clear in the first paragraph of their job description: Public Health Advisers "apply disease control and health promotion principles and methods, including interviewing, investigation, case management, and referrals." They "interview and re interview patients with communicable/preventable and environmental diseases, and their contacts and families, to elicit information in order to locate the source and detect or prevent possible spread of causes related to the known infection."

Sadly, disinvestment and layoffs in public health outreach and testing shrank their ranks during the Bloomberg Administration. Layoffs of employees involved in direct patient care continued into 2013. Reductions of hours – and outright closures – of dental clinics, TB clinics, and STD clinics decimated direct testing, referral, and treatment of vulnerable populations.

Ten years ago in 2010, there were over 450 Public Health Advisers working clinics and non-school bureaus. At the beginning of the current administration, there were 370 working in clinics and public health bureaus. As of April 2020, there are 284. The irony of Bloomberg funding the new crop of contract tracers is not lost on us, but we are pleased to witness this turn-around.

We support H+H's efforts to beef up their ranks immediately to slow the spread of COVID19, and to prevent a rebound "second wave" of infection. We welcome them on board and to be part of the DC37 family. We believe their work will help keep all New Yorkers healthier and safer. Their success will be felt by all New Yorkers for years to come.

**Testimony of the New York Immigration Coalition**
**Joint Oversight Hearing of the Committees on Health and Hospitals**
**NYC's Plan for COVID-19 Testing and Contact Tracing**

Max W. Hadler, MPH, MA

May 15, 2020

My name is Max Hadler and I am the Director of Health Policy at the New York Immigration Coalition (NYIC). The NYIC is an advocacy and policy umbrella organization for more than 200 multi-ethnic, multi-racial, and multi-sector groups across the state working with immigrants and refugees. Thank you to Committee Chairs Mark Levine and Carlina Rivera, and all members of the Committees on Health and Hospitals, for the opportunity to submit this testimony.

Immigrant New Yorkers have been disproportionately impacted by COVID-19 in almost every way imaginable – infection and death rates are highest in neighborhoods with large immigrant communities; immigrants represent more than half (53%) of NYC's essential workforce,[1] signifying greater ongoing exposure; undocumented and mixed-status families have been excluded from federal relief programs; and many immigrant New Yorkers continue to suffer reduced access to health services during the pandemic because of the state's persistent health insurance discrimination against those without status. These same communities must be at the forefront of the City's COVID-19 testing and contact tracing design, as a protection for those most affected by the pandemic as well as for the overall health, and social and economic well-being, of the City.

**Recruitment and training**

An effective testing and contact tracing plan for immigrant New Yorkers requires a linguistically and culturally responsive workforce. Some of this can come from training tracers, including dedicated content on the most prominent concerns in immigrant communities that may cause hesitation to participate in tracing efforts, such as the security of information collected, affordability of care received without coverage, the ever-present threat of federal immigration enforcement, and the consequences of being asked to self-isolate without job protection or paid leave. However, training cannot on its own create rapid-fire linguistic and cultural responsiveness on the timeline we are operating under. The City must hire a team of tracers who come from the communities they will be serving. The

[1] http://fiscalpolicy.org/wp-content/uploads/2020/04/Essential-Workers-Brief-Final-1.pdf

**New York Immigration Coalition**
131 W 33rd St. Fl 6
New York, NY 10001
212 627 2227
nyic.org

success of this effort can be enhanced by easing formal professional and experiential requirements, and placing a greater value on the linguistic and community experience of prospective tracers who know their neighbors best.

**Governance and structure**

For both recruitment and training, the City has an important existing resource – the network of community-based organizations (CBOs) that already have the trusted community relationships and knowledge that can help this effort succeed through ongoing education and outreach. CBOs' expertise needs to be harnessed as partners in developing tracing plans and disseminating information to communities through efforts such as the Council-funded Access Health NYC initiative, which must be restored in its entirety for FY2021 to help CBOs help their communities and the City overall in its fight against COVID-19. Health + Hospitals' NYC Care program has also greatly benefited from the outreach work of CBOs in the Bronx, Brooklyn, and Staten Island. New enrollment in NYC Care is paused, but these CBOs continue to do the critical work of disseminating information to their communities despite the challenges of isolation and remote work, and they must be included in tracing efforts where possible.

The NYIC is one of the groups participating in the nascent community advisory board convened by DOHMH and we expect that this body will be one of the venues for ongoing input of CBOs in the process. To generate more confidence in the accountability of the City to community advisory groups, we need a more transparent and public understanding of the testing and tracing governance structure. We find the Mayor's decision to strip control of the tracing effort – a classic public health strategy – from DOHMH, one of the world's premier municipal public health institutions, to be incomprehensible and poorly explained. Nonetheless, we have a positive working relationship with DOHMH *and* Health + Hospitals, and are prepared to work with whoever is involved as long as communities come first and our voices are part of the process.

**Data collection and security**

A primary concern for any information collection effort involving immigrant communities is the security of such data and clear messaging on its limited purpose. Many immigrant New Yorkers are understandably reluctant to provide personal information to government officials, so call scripts must be clear in the voluntary and confidential nature of the information solicited in case interviews, as well as reassurance that information gathered in tracing will not be shared with any government entity outside of New York City nor will be it stored for any purpose once the tracing effort is complete. There should also be reassurance that no information related to immigration status will be collected or stored. Further, data that are collected should not be linked to any other source that may contain immigration status-related information, including any records for existing patients at H+H. Messaging for existing H+H patients is also important to avoid confusing contact tracing with ongoing health care. We need greater clarity

on how H+H's role as a health care provider will not be conflated with its role as a contact tracing entity, and how the contact tracing effort will be conducted equitably and coherently for New Yorkers who are H+H patients and those who are not.

While we deeply appreciate the importance of contact tracing as a public health tool, we are concerned about any surveillance of immigrant communities in the current political context and oppose the use of tools such as Apple's and Google's Bluetooth-based technology to trace individuals through their phones. We also need assurances that there is firm security of the limited amounts of data collected by tracers and that such data are transmitted via secure methods, particularly given the dispersion of the tracing effort with so many individuals working remotely. A surveillance phase-out plan should also be instituted to instill greater confidence in the temporary and limited nature of the tracing effort.

**Worker and family protections**

Hundreds of thousands of immigrant New Yorkers have been left out of federal COVID-19 relief packages, including the exclusion of undocumented and mixed-status families from stimulus payments and the lack of job protection or unemployment benefits for people without work authorization. This lack of protection and support inevitably informs decisions that these families and workers must make if they face the need to self-isolate and skip work because they have been exposed to the virus. We cannot view contact tracing as an isolated public health strategy to identify exposure; rather we must contemplate the broader context in which city residents make decisions about their day-to-day lives, which for successful engagement with many immigrant families requires a greater degree of support than they currently receive. The City's initiative to distribute cash assistance from the Open Society Foundations is a start, but a significantly greater investment is needed in the form of a City emergency cash assistance fund for New Yorkers left out of the federal relief packages. The City should explore additional paid leave protections and financial supports for anyone who is told to self-isolate as a result of contact tracing.

The concerns of immigrant communities are paramount to the success of New York's fight against COVID-19. Immigrants continue to be the backbone of our city's economy and will continue to suffer greater exposure to the novel coronavirus because of their disproportionate representation among the City's essential workforce. If we do not create a plan and supportive policies that meet the needs of immigrant New Yorkers, we will fail to beat COVID-19.

Thank you for the opportunity to testify today.

COPE 10027
COALITION ON POSITIVE HEALTH EMPOWERMENT

127 West 127th Street Suite 419, NYC

Office (212) 426-3895

**Testimony for the New York City Council Committee on Health**
**May 15, 2020**

I am testifying on behalf of the Coalition on Positive Health Empowerment (COPE). My Name is Gail Brown, Director of Advocacy with COPE. I am here to urge you to fund the Viral Hepatitis Initiative. In light of the current crisis New York City is facing with the COVID-19 pandemic, it is especially urgent that we don't overlook pressing health care needs affecting our most vulnerable populations, the ones that are the hardest hit by this pandemic. While all of the focus is on COVID-19, we cannot afford to lose all of the gains we made in HIV/AIDS with low numbers of new cases and high rates of viral suppression along with gains in curing those living with hepatitis C. With the loss of funding for the community programs addressing these chronic diseases, the number of new cases is likely to rise.

The communities with the highest rates and the most deaths of COVID-19, are the same communities with high rates of HIV/AIDS, Viral Hepatitis, Diabetes, Heart Disease, and Obesity among other chronic diseases. At COPE, we are on the ground working in these communities screening for HIV and hepatitis C, bringing health awareness and health literacy programs, support groups, wellness programs, and patient navigation. We work with the people who are most challenged accessing health care, particularly accessing a cure for hepatitis c. These are the people with substance use issues, people with mental health issues, the homeless, those who lack insurance, and other issues that make accessing care challenging. Any barrier patients encounter are challenges we overcome every day. We meet people where they're at; on the corner, at the methadone clinic, we knock on their door, and show up whenever and wherever to bring them to their first appointment and follow up until they are cured. We have seen people's lives change. They have more energy and enthusiasm for life. They go on to become productive members of our city and begin to enjoy living their life.

We are from the community providing services to the community. We are trained peers who have lived experience. Community residents trust us because they know us, because we know where they come from and the challenges they are facing. Without NYC Council Viral Hepatitis Initiative funding, we will more than likely have to shut our doors. Many depend on us to walk them through the medical bureaucracy. At COPE, because of our experience and knowledge of the systems, we are able to streamline the process for people testing positive for hepatitis C.

A woman who immigrated to NYC many years ago had been living with hepatitis C for a long period of time. She got turned down repeatedly for medical care because she was not a resident and was not able to secure insurance. We were able to get her medical care and medication and today she is cured of hepatitis C. Through this process, she attended our programs helping her to stay engaged in care and providing support. In conversation with me, she reported that she is no longer feeling depressed and

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she has more energy and enthusiasm. She is starting to venture out of her home and engage in social activities and dance classes. Another young man from the Bronx, screened positive for hepatitis C. He was a substance user and confided in us that he wanted to change his life, but didn't know where to get help. We brought him to the doctor and started him on medication for hepatitis C. While on his regimen, we got him into a detox and then rehab. While in treatment, we stayed connected and ensured he stayed on his regimen. He is now cured of hepatitis C and although still struggling, knows where he can come for help and knows that he has people who care.

Without this funding, we are sure to see a sharp increase in cases of hepatitis C. Many of our community health programs have been struggling to survive and might not be able to continue. COPE will more than likely be forced to close our doors. Our most vulnerable populations and our most marginalized communities will have lost an essential service, an organization they depend on. Please continue to fund the Viral Hepatitis Initiative to continue the tremendous amount of progress we have made and can continue to make with this funding.

Thank you for allowing me to submit this testimony.

KCS
WWW.KCSNY.ORG
THE KOREAN COMMUNITY SERVICES OF METROPOLITAN NEW YORK, INC.

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*Since 1973*

**Testimony for the New York City Council**
**Committee on Health**
**Oversight: - NYC's Plan for COVID-19 Testing and Contact Tracing**
**May 15, 2020**

To Chairperson Levine and Members of the Committee on Health,

My name is Paul Lee and I am a project coordinator and grant specialist at Korean Community Services of Metropolitan New York (KCS). The **NYC Council Viral Hepatitis Initiative** currently funds 34 organizations to provide hepatitis B and C prevention and access to care services, as well as training and technical assistance for providers (see list of organizations below). The Initiative currently fully supports employment for more than 50 people: syringe exchange program peers, patient navigators, and training and technical assistance providers.

The Viral Hepatitis Initiative serves people at highest risk for hepatitis B and C, HIV, overdose and coronavirus, including the uninsured, immigrants and people who have used drugs. The Initiative has served over 15,000 people at risk for hepatitis B or C in navigation programs and linked over 6,500 to care. The initiative has trained and employed over 58 patient navigators and over 111 Peers from syringe exchange programs, and has trained over 2,000 clinical providers in hepatitis B and C testing and treatment. Currently, the programs are building telehealth capacity to continue critical prevention and access to care services to address the COVID-19 pandemic.

As a program provider of the Viral Hepatitis Initiative since 2014, KCS has dedicated itself to the prevention of hepatitis B through widespread free testing, education, and providing culturally competent patient navigation services for Koreans and Asian Americans with chronic infections. The vast majority of those we serve are community members of immigrant backgrounds, low-income status, limited English proficiency, and lack of healthcare coverage. Moreover, since the outbreak of COVID-19 and the enactment of the statewide PAUSE order, KCS has been on the frontlines assisting the many suffering individuals across the city and sustaining our support for existing patients.

Although the hearing today pertains to COVID-19 contact tracing, I would like to emphasize the widespread impact that the on-going pandemic has had on our community, especially for those living in Queens, and the individuals we serve through the Viral Hepatitis Initiative. As highlighted before, the majority of our patients are immigrants who face significant disparities in accessing health services and outcomes. Likewise, COVID-19 has had a disproportionate effect on these same demographics many of whom live in Queens, which currently has the highest number of infected individuals.

While navigating the present crisis is of the foremost importance for the sake of all New Yorkers, our collective health, and economic stability; I ask you all to keep in mind that hepatitis B/C and other health issues have not disappeared, and will only exacerbate the current hardships for many vulnerable

residents. In spite of the difficult economic situation and budgetary concerns the city and state faces, I ask that you continue to support the Viral Hepatitis Initiative in the upcoming fiscal year. Not only is sustaining this initiative a comparatively small expense in the larger context of the budget, the resulting effects and work made possible by this support will help drive down the overall financial impact that hepatitis B and C have on our health system every year, and also sustain the nearly 170 health workers who provide critical patient/peer navigation for suffering individuals.

Without your continued support, thousands of New Yorkers will face severe health complications from hepatitis, and innumerable others will be at risk of contracting the disease. These individuals already face disproportionate socioeconomic inequalities, and the culturally competent programs funded by the Viral Hepatitis Initiative make a tangible and efficacious impact on the on-going hepatitis epidemic. Approximately 230,000 NYC residents are estimated to be infected with chronic hepatitis B, and 116,000 people are believed to be infected with chronic hepatitis C. Given these high rates of infection, it is crucial to sustain the Viral Hepatitis Initiative not only to address this largely overlooked health crisis, but as New York City currently serves as both a model and beacon of hope for similar initiatives across the nation and the world.

I sincerely thank the members of the City Council and Committee on Health for supporting the efforts of CBOs like KCS in the past and pray that your support will continue into the future. Truly, without your backing, our work for the community and assistance for at-risk individuals would not be possible. I would also like to praise you for the dedication and work you have all done on behalf of NYC residents like myself. We are all in this together and with your leadership, I am confident that we will emerge stronger, more empathetic, and more unified than ever before.

Thank you for your time and consideration.

Sincerely,

Paul Lee
Project Coordinator/Grant Specialist
Korean Community Services of Metropolitan New York, Inc. (KCS)

Written Testimony

New York City Council

Unified NYC Viral Hepatitis Initiative

Monday, March 31st, 2020

Robert Desrouleaux

Program Director The Hepatitis C Mentor and Support Group, Inc.

2525 Hone Ave # 1

Bronx, NY 10469

(347) 886-9558

Thank you for the opportunity to write to you today. I want to thank the council members for supporting the hepatitis community in the past. I am writing you as a representative of the Hepatitis C Mentor and Support Group. I have been working for 6 years on the ground in with the underserved communities, providing training on education and supportive services within syringe exchange programs and drop in centers. I work closely with the Founder/ Executive Director of HCMSG, Ronni Marks who in addition to being a patient, has experience working with both patients and providers. Educational groups and supportive patient mentoring services have been shown to be important elements of successful and cost effective medical care for patients with Hepatitis C and other chronic health conditions. These services improve the quality of life, as well as medical outcomes for patients.

The training HCMSG provides for healthcare providers help them to have a better understanding of how to work with all patients with an emphasis on high risk populations, such as people with substance use disorder, those co infected with HIV, the LGBTQ community, Youth and Women of child bearing age dealing with Hepatitis C.

Our hope is to see us provide a model for the entire country, with NYC as the first City to eliminate Hepatitis C.  We need increased services for hepatitis, peer navigators, harm reduction and syringe exchange services.

This is why it is critical that we reduce missed opportunities to screen and diagnose patients who seek care in emergency rooms and hospitals as well as educating providers and staff on the stigma faced by people who use drugs. There are opportunities to move towards elimination by increasing the focus on treating patients who are in the hospital for extended periods of time. Education is needed in overdose prevention, Hepatitis and HIV. People need to understand the syndemic connection between substance use and infectious disease.

As an educator in the field and someone who has witnessed the lack of knowledge in the communities, I can tell you firsthand what an impact this virus has on the lives of those affected. There is such power in having supportive services and patient navigators. It is essential for patients to work with people who understand what they are going through and can help them get through the process, making it easier for patients to adhere to treatment. In many cases it has helped to reduce the feeling of stigma associated with having Hepatitis.

Please help us ensure that all New York City residents have access to Hepatitis C testing, treatment and care regardless of race, gender, or economic status.

Thank You!

Reference:

1. NYC Department of Health; 2016 Annual Report: Hepatitis B and C. www1.nyc.gov/assets/doh/downloads/pdf/cd/hepatitis-b-and-c-annual-report-2016.pdf

The **NYC Council Viral Hepatitis Initiative** currently funds 34 organizations to provide hepatitis B and C prevention and access to care services, as well as training and technical assistance for providers (see list of organizations below). The Initiative currently fully funds employment for more than 50 people: syringe exchange program peers, patient navigators, and training and technical assistance providers from the communities they serve. **The Initiative at Montefiore Comprehensive Care Center fully funds employment for 1 Hepatitis C Care Coordinator.** The Viral Hepatitis Initiative serves people at highest risk for hepatitis B and C, HIV, overdose and coronavirus, including the uninsured, immigrants and people who have used drugs. The Initiative has served over 15,000 people at risk for hepatitis B or C in navigation programs and linked over 6,500 to care. The initiative has trained and employed over 58 patient navigators and over 111 Peers from syringe exchange programs and has trained over 2,000 clinical providers in hepatitis B and C testing and treatment. Currently, the programs are building telehealth capacity to continue critical prevention and access to care services to address the COVID-19 pandemic.

**The Viral Hepatitis Initiative Program, Check Hep C at Montefiore Medical Center** has been providing fully-integrated, individualized viral hepatitis services to Bronx residents since 2014. City Council Discretionary Funding will cover 1 FTE Patient Navigator. The Hepatitis C (HCV) Patient Navigator enrolls all patients identified to have HCV in the Check Hep C program. Through a comprehensive assessment, barriers to care are identified. Following the results of the assessment, the Patient Navigator develops an individualized care plan with the treating medical provider to ensure adherence to HCV care and treatment. Referrals for substance abuse treatment, mental health care, housing, transportation, diagnostic testing, and other supportive services are arranged by the Patient Navigator. While the patient is undergoing medical evaluation, the Patient Navigator case conferences with a multi-disciplinary team to identify potential treatment concerns and to discuss the patient's progress along the HCV cascade of care. The Patient Navigator is responsible for medication and pharmacy coordination as well as treatment adherence to ensure a successful response to treatment. Lastly, the Patient Navigator in conjunction with the team develops a post-treatment follow-up plan to minimize HCV re-infection. The Initiative at Montefiore has served over 500 patients and we have provided Hepatitis C treatment for more than 300 patients and cured 200.

The Bronx is a community with high levels of poverty, poor health outcomes, and chronic HCV. In the Bronx, 14% of Puerto Rican men are estimated to have HCV compared to 1-2% of adults nationally. HCV patients in the Bronx face additional barriers related to preferred language, transportation, health literacy, substance use, disorders, serious mental illnesses, and housing insecurity. The community benefits directly from the Check Hep C program as it has previously demonstrated that the overall HCV prevalence among adults in the Montefiore outpatient clinics is 7.7%. The Check Hep C program provides services to those directly impacted by HCV in the Bronx community. **Without the Viral Hepatitis Initiative Program at Montefiore, HCV patients in The Bronx will lose on receiving essential services and an opportunity to cure them of a disease that is CURABLE.**

## Viral Hepatitis Initiative Funded Organizations (FY20)

African Services Committee
After Hours Project
AIDS Center of Queens County
Alliance for Positive Change
APICHA Community Health Center
Bedford-Stuyvesant Family Health Center
BOOM!Health
BronxCareHealth System
Brownsville Multiservice Family Health Center
Charles B. Wang Community Health Center
Community Health Action of Staten Island
Community Healthcare Network
Empire Liver Foundation
Family Services Network of New York
H+H Bellevue Hospital
H+H Coney Island Hospital
H+H Elmhurst Hospital
H+H Kings County Hospital
Harm Reduction Coalition
Hepatitis C Mentor and Support Group
Housing Works Crosby Street
Kingsbrook Jewish Medical Center
Korean Community Services
**Montefiore Comprehensive Care Center**
Montefiore Einstein Liver Center
New York Harm Reduction Educators
NYU Seventh Avenue Family Health Center
Positive Health Project
Praxis Housing Initiatives
Public Health Solutions
Safe Horizon Street works
St. Ann's Corner of Harm Reduction
VOCAL-NY
Washington Heights CORNER Project

**TESTIMONY BEFORE THE NEW YORK CITY COUNCIL**
**HEALTH AND HOSPITAL COMMITTEES**
**Friday, May 15, 2020--Via Zoom**
**10:00 AM, New York City, New York**

Thank you, NYC speaker Corey Johnson, Chairpersons Rivera and Levin, members of the committees on Health and on Hospitals and other Council members attending this import hearing, for this opportunity. The impact of COVID-19 has been overwhelming. We at the Latino Commission on AIDS, the Hispanic Health Network and community partners are extremely concerned, alarmed and shaken by the impact of COVID-19 on our City and especially among people of color. We want to make sure that everyone is accurately informed, fear-free, safe, healthy and stigma-free, particularly those most vulnerable such as older adults, people with compromised immune systems and the already socially and economically marginalized.

As we face COVID-19, we inquire on the health status of Hispanic/Latinx communities. We constitute 29% of New York City and 18% in New York State and we play a vital role in the progress in New York City. Despite this central role of Hispanics/Latinx as one of the most thriving economies in the country, the health and wellbeing of Hispanic/Latinx New Yorkers is in serious jeopardy. We represent more than 31.2 % of total deaths, 30.7% of non-hospitalized individuals and 32.3% of non-fatal hospitalized due to COVID-19 as of May 14, 2020. The data shown only partially reflects the real impact of COVID-19 on Hispanic/Latinx. The barriers of accessing health care faced by Hispanic/Latinx are many:

- lack of health insurance or underinsured;
- poverty and lower socioeconomic status - incarceration, homelessness, and employment instability impacting their ability to enact social distancing measures;
- dependence on an already financially distressed public health system;
- discrimination in health care delivery and public health policies;
- insufficient health research on Hispanic/Latinx populations;
- lack of Hispanic/Latinx, linguistically appropriate and/or culturally competent health care and support services;
- Homophobia, Transphobia and Xenophobia are a barrier for our communities;
- Immigration law enforcement and restrictions on access to health care and economic incentives;
- lack of multi-cultural mental health services, safe drug treatment programs. Among other reasons

As we recognize the tremendous work and leadership of Mayor's Bill de Blasio administration, our Health Commissioner Dr. Oxiris Barbot, Dr. Mitchell Katz from Health and Hospitals, we want to express our eternal gratitude for all of those who have responded to this public health crisis, including many Latinx on the frontlines.

We also want to ensure that we move forward on this new reality with the high sense of responsibility and community engagement to make a difference on how we contain and address the challenges that COVID-19 represents. We request that our Mayor, NYC Council, all elected and appointed officials and all New Yorkers work together to develop initiatives that embrace the historical role of our well respected New York City Department of Health and Mental Hygiene in leading COVID-19 testing and contact tracing rooted in the communities most impacted

We strongly believe that this public health crisis represents an opportunity to re-design, re-imagine with innovation to tailor a long term public health and access to care strategy superior to what we have currently.

We request to address the barriers listed above in accessing health care and support services in all communities. We also request that the workforce assigned to implement the community broad testing and contact tracing strategies reflect the racial and cultural diversity of our City. Anything different than this will be counterproductive to win this public health battle. We will work hard to contribute with all our partners to defeat COVID-19 and erase all health disparities in our beloved NYC. Thank you

Respectfully submitted by

**Guillermo Chacón**
President, Latino Commission on AIDS
Founder, Hispanic Health Network
24 W 25th St. 9th Floor
New York, NY 10010
direct (212) 584-9304
cell (212) 920.1611
Visit http://www.latinoaids.org

ZERO HOMOPHOBIA MAY 11-17 WEEK AGAINST HOMOPHOBIA ZERO TRANSPHOBIA NOV 15-20 WEEK AGAINST TRANSPHOBIA


LATINO
COMMISSION
ON AIDS
HISPANIC
HEALTH
NETWORK

# NYC Council Viral Hepatitis Initiative Testimony

**Background:** The **NYC Council Viral Hepatitis Initiative** currently funds 34 organizations to provide hepatitis B and C prevention and access to care services, as well as training and technical assistance for providers (see list of organizations below). The Initiative currently fully funds employment for more than 50 people: syringe exchange program peers, patient navigators, and training and technical assistance providers from the communities they serve. The Viral Hepatitis Initiative serves people at highest risk for hepatitis B and C, HIV, overdose and coronavirus, including the uninsured, immigrants and people who have used drugs. The Initiative has served over 15,000 people at risk for hepatitis B or C in navigation programs and linked over 6,500 to care. The initiative has trained and employed over 58 patient navigators and over 111 Peers from syringe exchange programs and has trained over 2,000 clinical providers in hepatitis B and C testing and treatment. Currently, the programs are building telehealth capacity to continue critical prevention and access to care services to address the COVID-19 pandemic.

The Viral Hepatitis Initiative allow us to hire an full time patient navigator who help around 75 positive Hepatitis B positive immigrants patients to navigate the NYC health system for treatment and access to medication.

African Services Committee conducted Hepatitis testing events in the community in all 5 boroughs through the year.ASC tested 400 people in 2019 with 15% Hepatitis B positivity rate and provide Hepatitis B vaccine for susceptible patients.

The Viral Hepatitis Initiative Funding is essential to continue providing testing, vaccination and access to healthcare to the most vulnerable people in NYC.

Halimatou Konte.
Health Program Director
African Services Committee
429 West 127th street, New York, NY 10027

T: 212-222-3882 ext 2118.
F: 212-222-7067

E: halimatouk@africanservices.org
www.africanservices.org.