Oversight Hearing: Long Term COVID Treatment in NYC Hospitals
Committee on Hospitals and Subcommittee on COVID Recovery and Resiliency
06/27/22

Good morning Chairpersons Narcisse, Moya, and members of the Committee on Hospitals and the Subcommittee on COVID Recovery and Resiliency. I am Dr. Ted Long, Senior Vice President for Ambulatory Care at NYC Health and Hospitals and I have served as the Executive Director of the NYC Test & Trace Corps since its launch in June 2020. Thank you for the opportunity to testify on the work NYC Health + Hospitals has led to understand, treat, and support Long COVID patients.

While we are still learning about the depth and extent of Long COVID, NYC H+H is proud to be at the forefront of offering comprehensive clinical services to meet the needs of patients who are navigating this emerging condition. Our commitment to supporting Long COVID patients has resulted in the creation of two key program: (1) through the opening of new, community-based *COVID-19 Centers of Excellence (COEs)* in neighborhoods that experienced some of the most devastating impacts of the pandemic; and (2) through the launch of AfterCare.

COEs

NYC H+H recognized early on that Long COVID was an emerging clinical issue, and began planning to open COVID-19 Centers of Excellence sites in Fall 2020. It was critical to our hospital system leadership that the COEs were located in regions of the City hardest-hit by the pandemic (Bushwick, Jackson Heights, and Tremont) in order to deepen access to specialized healthcare services in communities most likely to need them. The COEs provide short and long-term care for those recovering from COVID-19. Services include:

- Lung care and supplemental (extra) oxygen
- Heart care
- X-rays, scans, and ultrasounds
- Mental health services for anxiety, depression, post-traumatic stress disorder, and psychological distress
- Rooms to safely isolate patients who may have COVID-19 or are being tested for COVID-19

COEs work to treat the whole patient, and thus offer comprehensive primary care health services, including cancer screenings, dental and vision care, diabetes management, podiatry, adult medicine, pediatrics, and much more for not only patients with Long COVID, but for all patients and their family members without exception. Patients can be referred to the Centers of Excellence after a hospital visit, through their primary care provider, or through our Aftercare program to receive short- and long-term care to address their recovery from COVID-19.

AFTERCARE

In April 2021, NYC Test & Trace Corps launched the AfterCare program, which connects New Yorkers with Long COVID to resources to support them in their recovery process. To address the various symptoms Long COVID patients may experience, as well as the social and economic impacts that the condition may create, such as loss of employment or social isolation, AfterCare

Navigators connect patients to holistic resources that address physical health, mental health, community support and financial assistance.

AfterCare makes phone calls to former COVID-19 cases who were still reporting symptoms at the end of isolation. Clients are directed to the AfterCare website, nyc.gov/aftercare, where they can select the resources most relevant to their needs, and get connected. New Yorkers who are suffering from or believe they may have Long COVID can also directly call AfterCare Navigators, health outreach specialists with experience supporting people during their COVID infections. Through this program, people can be assessed for their specific health and social needs and connected to Long COVID resources. Individuals suffering from Long COVID can call 212-COVID19 (212-268-4319), select their preferred language, and press 4 to speak to an AfterCare navigator.

Since the launch of AfterCare in April 2021, AfterCare Navigators has sent more than 334,000 texts and completed over 114,000 phone referrals for New Yorkers who have recently been diagnosed with COVID-19, following up approximately four weeks later if the patient reported having symptoms on their last day of COVID-19 monitoring. AfterCare Navigators have sought to prioritize patients in zip codes identified by the Taskforce on Racial Inclusion and Equity (TRIE) as disproportionately impacted by COVID-19 and other health and socioeconomic disparities.

NYC Health + Hospitals has a long history of meeting the healthcare needs of all New Yorkers regardless of insurance, income, and immigration status. We look forward to continuing this work to partner with the City Council and all local stakeholders to expand access to critical healthcare services in the City. Thank you to the committees for your attention to this important topic and for your continued support of NYC Health and Hospitals. I look forward to answering any questions you may have.

CACF
Coalition For Asian American Children+Families

New York City Council
Committee on Hospitals and Subcommittee on COVID Recovery and Resiliency
June 27, 2022

Testimony of Amy Lin, Policy Fellow
Coalition for Asian American Children and Families (CACF)

Hello, my name is Amy Lin, and I am the Health Policy Fellow at CACF, the Coalition for Asian American Children and Families. Thank you very much to Chair Narcisse and Chair Moya for holding this hearing and providing the opportunity to testify.

Founded in 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 American Pacific Islander (AAPI) population comprises nearly 18% of New York City. Many in our diverse communities face high levels of poverty, overcrowding, uninsurance, and linguistic isolation. Yet, the needs of the AAPI 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 AAPI New Yorkers. Working with over 70 member and partner 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.

Nearly 19 million people reside in the New York City metropolitan area, and over 800 different languages are spoken. Because of New York's linguistic diversity, it is incredibly important to ensure language access. Language barriers are a huge obstacle faced by many folks in immigrant communities, and especially in the AAPI community. In New York City, AAPIs have the highest rate of linguistic isolation of any group, as 46% have limited English proficiency (LEP), meaning that they speak English less than very well, according to a recent report from the New York City Department of Health and Mental Hygiene. Moreover, more than 2 in 3 Asian seniors in New York City are LEP, and approximately 49% of all immigrants are LEP.

Language barriers can prevent folks from accessing vital services like healthcare. Despite there being 76 language access policies targeting healthcare settings in New York, many LEP patients still report facing difficulties like being unable to find an interpreter that speaks their dialect or being unable to fill out paperwork because a translated version in their language does not exist. A lack of linguistically accessible services in healthcare settings can have grave consequences: 52% of adverse events that occurred to LEP patients in US hospitals were likely the result of communication errors, and nearly half of these events involved some physical harm.

In the summer of 2021, we conducted a rapid needs assessment in collaboration with the NYU Center for the Study of Asian American Health and the Chinese-American Planning Council. We surveyed over 1000 adults of Asian, Hispanic/Latinx, or Arab descent living in the metropolitan New York area to assess the current and ongoing needs of the community during the COVID-19 pandemic.

CACF
Coalition For Asian American Children+Families

This study highlights the disproportionate impact that the COVID-19 pandemic has had on the New York Asian American community and demonstrates the importance of language access. Specifically, the study found 1 in 3 (34%) Asian American adults reported language barriers being a challenge during the pandemic. Furthermore, 27% of Asian American respondents indicated that they felt like they did not have regular access to timely, accurate information during the COVID-19 pandemic in their language. The study also shed light on the specific language barriers that Asian American folks were facing: Chinese, Korean, and Bangladeshi adults reported high rates of difficulty waiting for an interpreter, while Korean, Japanese and other Asian adults reported high rates of difficulty getting written materials in their preferred languages. Being unable to access vital COVID-19 information or health services can be a threat to one's livelihood, so ensuring language access for all New Yorkers must be prioritized. LEP patients undergoing long-term COVID-19 treatment in New York City hospitals deserve to have linguistically accessible and culturally responsive services so that they can remain informed about their health-related decisions and recover from COVID-19.

Because ensuring language access is necessary for LEP patients to receive long-term COVID-19 treatment, we strongly encourage the City to prioritize expanding language access and services for COVID-19 efforts and social services and to truly enforce the language access plans in hospitals so that LEP patients have equal access to long-term COVID-19 treatment.

In addition to a need for linguistically accessible services, many patients with long-term COVID-19 around the nation report having heightened mental health challenges. Experiencing COVID-19 symptoms for many weeks can exacerbate mental health problems, which is why mental health services must be an integral part of long-term COVID-19 treatment in New York City hospitals. AAPI New Yorkers are less likely to be connected to mental healthcare than White New Yorkers, as only 38.2% of AAPIs with depression self-report as receiving mental health treatment versus 58.3%. **The City must prioritize providing linguistically accessible and culturally responsive mental healthcare to all New Yorkers experiencing long-term COVID-19.**

Overall, we see a need for more intentional collaboration between the City and community-based organizations to better identify language access gaps and mental healthcare access gaps and to find solutions that will have a direct impact on our communities.

Thank you very much for your time.

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June 22, 2022

By E-mail:
Honorable NYC Council Finance and Committee on Health
New York City Hall
City Hall Park
New York, NY 10007

RE: Hearing on Long-Term COVID Treatment in New York City Hospitals: HANAC Health NYC testimony letter to support funding increase in FY2023.

To the Honorable NYC Council Committee on Health:

My name is Enrique Jerves, and I am the Program Director for HANAC's Health Access Program. I am humbly submitting this correspondence to serve as a testimonial correspondence to support the expansion of Long-Term COVID-19 Treatment in New York City Hospitals in FY 2023.

As you are keenly aware, the long-term COVID-19 has significantly impacted the New York State Healthcare system due to the extended health treatment these clients need. While clients from different communities suffered during this pandemic, immigrant communities are among the most disparately affected groups. Historically, underserved immigrant communities face incredible obstacles in receiving adequate health care during regular times; during this pandemic, the immigrant community has faced even more significant difficulties obtaining primary care, specialist support, hospitalization, and COVID-19 healthcare resources needed for people that have the COVID-19 Virus. The immigrants usually encounter problems related to language support and, in most cases, have expressed concerns about public charge policies. My experience helping the immigrant community allowed me to learn about the needs of this community.

The public health treatment for long-term COVID-19 needs to improve efficiencies and provide New York residents access to primary care and high-quality health care services. COVID prevention requires permanent access to tests and primary care services for treatment. To continue with endless efforts to prevent infections, funding for testing, education, outreach, and health navigation is crucial to avoid the Virus's spread, encourage and expand telehealth, and fully cover the doctor visits and treatments needed to recover from the Virus.

To reiterate, before the onset of the COVID-19 , immigrant communities were already vulnerable to illnesses such as but not limited to depression, substance abuse, and other negative factors such as high blood pressure or diabetes. Now, mental health experts fear that many more will be prone to trauma-related disorders due to this pandemic. For example, as we have heard on the news, immigrants are impacted by the loss of a family member, loss of employment, lack of

health coverage, lack of access to testing, and most cases, have no information about long-term COVID effects. During the pandemic, we assisted in providing essential social services during the pandemic. We helped many immigrants obtain primary care, health insurance, and referrals for financial assistance in New York City programs. At the height of the pandemic, our programs continued to provide essential services for the immigrant communities. These individuals may be at higher risk of developing long-term challenges. The costs involved in health care in New York State are already high; it is even worse for individuals who do not qualify for health insurance.

Many uninsured communities have yet to receive medical coverage due to a lack of insurance eligibility, or they are afraid of immigration policies. This effort to communicate to the New York City residents about the risk of developing long-term COVID has increased previous budget cost of operations.

Thank you for the opportunity to provide our testimony for COVID's long-term treatment funding. Please let us know if you have any questions or need additional information about these requests. Please do not hesitate to let me know if you need further information.

Respectfully Submitted,

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Testimony re: Long-Term COVID Outcomes and Recommendations

Submitted to:

Committee on Health and Subcommittee on COVID Recovery & Resiliency

Submitted by:

Francesca Perrone, Policy Analyst at Hispanic Federation

Thank you, Chair Moya, and all other committee members, for allowing me to present this testimony on behalf of the Hispanic Federation; a non-profit organization seeking to empower and advance the Hispanic community, support Hispanic families, and strengthen Latino institutions through direct service programs and legislative advocacy.

Long-Term COVID at a Glance

In October of 2020, the World Health Organization (WHO) identified Post-Acute Sequelae of SARS-CoV-2 ("Long COVID"). Long COVID can be defined as symptoms that individuals infected with COVID-19 experience months after their initial infection that cannot be explained by an alternative diagnosis.[1] Approximately 20% of COVID-19 patients will experience this phenomenon to some capacity.[2] Symptoms can vary from patient to patient and include, but are not limited to fatigue, shortness of breath, and neurological disorders.[3] It is important to note that anyone who has been infected with the virus that causes COVID-19 can experience long-COVID symptoms regardless of illness severity. Thus, the best way to prevent long-COVID is to prevent the transmission of COVID-19 by continuing social distancing and vaccination efforts.

Affected Groups

Since the Coronavirus pandemic began, Latino communities have experienced a disproportionate burden of COVID-19 infections. Data from the Centers for Disease Control and Prevention (CDC) shows

[1]Coronavirus disease (COVID-19): Post COVID-19 condition https://www.who.int/news-room/questions-and-answers/item/coronavirus-disease-(covid-19)-post-covid-19-condition

[2] Coronavirus disease (COVID-19): Post COVID-19 condition https://www.who.int/news-room/questions-and-answers/item/coronavirus-disease-(covid-19)-post-covid-19-condition

[3] Coronavirus disease (COVID-19): Post COVID-19 condition https://www.who.int/news-room/questions-and-answers/item/coronavirus-disease-(covid-19)-post-covid-19-condition

that the Latino population tests positive for COVID-19 at a higher rate compared to other groups.[4] Additionally, the pandemic has magnified existing social conditions that exacerbate health outcomes. While strides have been made to curb the transmission of disease through vaccination efforts, social distancing, and isolation protocols, the virus lingers. Since long-COVID is not easily diagnosed there is limited racial/ethnic data to understand the burden of disease across groups at this time. Researchers are working to understand what groups of people are more likely to develop symptoms and why. However, since Latinos carry a significant burden of COVID-19 diagnoses, there is consensus that they are at high risk of developing long-Covid symptoms compared to other groups.

To combat long-COVID, the city must ensure that all NYC residents, including undocumented immigrants, have access to health insurance. Non-citizens are more likely part of the informal economy or have low-wage jobs, which typically do not offer health insurance. Even if employers provide health insurance, it may be cost-prohibitive. Undocumented immigrants are uninsured at a rate more than three times that of other noncitizens in New York City and more than six times greater than the uninsured rate for the rest of the city.[5] The city has programs to ensure access to healthcare for residents regardless of immigration status, but our community members are often unaware that these services exist.

Current Treatments

Since long-COVID symptoms can range from mild to acute, the treatment options for patients may vary. Presently, a one size fits all treatment does not exist. Across the United States clinics have a framework in place with customized treatments, coordinated care, and ongoing support.[6] Treatment begins with a comprehensive medical evaluation. Once symptoms are assessed, treatment can be tailored to the needs of the patient. Under this framework specialists must collaborate seamlessly for patient recovery. Ongoing care ensures that patients are monitored for a prolonged period to establish whether a particular treatment is effective, and what modifications should be made.

In New York, institutions such as Mount Sinai, Columbia University, and Health + Hospitals are offering care to patients with long-COVID symptoms and studying the impact of treatment on outcomes. These

[4] "Health Equity Considerations & Racial & Ethnic Minority Groups" https://www.cdc.gov/coronavirus/2019-ncov/community/health-equity/race-ethnicity.html

[5] Improving Immigrant Access to Healthcare in New York City https://www1.nyc.gov/assets/cidi/downloads/pdfs/immigrant_health_task_force_report.pdf

[6] "Management of Post-COVID Conditions: Evaluating and Caring for Patients with Post-COVID Conditions." https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-care/post-covid-management.html

sites have a range of specialists that can address the specific needs of patients.[7] While treatments exist in NYC, minority communities tend to lack access to health clinics that provide comprehensive care.[8] Additionally, undocumented members of the Latino community, who make up a significant number of COVID-19 cases, may forgo seeking healthcare for fear of retaliation[9] or simply because they do not know what services they are eligible for. Moreover, long-COVID patients who do not have a positive COVID-19 test are often denied access to therapeutic services for diagnosed patients.

Recommendations

It is vital for New York City to adopt a better understanding of long-COVID by creating a long-COVID task force and community-based care center clinics to work directly with patients to study and treat long-COVID. The clinics must have a commitment to providing care without discriminating against race, income, insurance status, or immigration status. We urge the City Council to partner with trusted community organizations to create messaging campaigns to educate people in person and on the ground about the treatment centers that offer support for long-COVID.

Second, to address the burden of long-COVID, we must ensure that robust COVID-19 testing continues. As previously mentioned, patients who are presumed COVID-19 positive but do not actually get tested are frequently denied therapeutics or care from long-COVID clinics. The City must ensure that COVID-19 testing continues in our most vulnerable communities and that culturally and linguistically competent public health workers are there to monitor patients and direct them to appropriate resources. Additionally, lacking a positive COVID-19 test should not exclude symptomatic patients from having access to long-COVID clinics. Limiting access to care will further exacerbate inequities amongst racially and ethnically marginalized and low-income populations, who experience more barriers to testing and therefore are more likely to not have a positive test.

To address the lack of health care access that would enable undocumented immigrants to address long-COVID, the City Council should support public education campaigns of current programs. One example is NYC Health + Hospital's NYC Care Program guaranteeing low-cost and no-cost services to New Yorkers who do not qualify for or cannot afford health insurance based on federal guidelines. This is the nation's largest and most comprehensive initiative to guarantee health care for New Yorkers, regardless of

[7] "Post-COVID Care Clinics" https://www1.nyc.gov/assets/doh/downloads/pdf/covid/covid-19-care-clinics.pdf
[8] "Structural Racism in Historical and Modern US Health Care Policy" *Health Affairs Vol. 41, No.2* 22.
[9] Fear of retaliation due to immigration status.

immigration status or ability to pay. The City should launch a wide-scale campaign in multiple languages to distribute information about this program. Information should be distributed in subway ads, television, radio, and local newspapers in Spanish and in a variety of other languages. The availability of this program is not sufficient – the City must intentionally distribute information about how to apply for and access health care services via NYC Care so all NYC residents are aware of this service. Public education campaigns in a variety of languages about long-COVID can also encourage undocumented immigrants and residents with limited English language proficiency to report symptoms and seek care.

Lastly, we recommend that the City continue to bolster its efforts to curb the spread of disease. This includes vaccination efforts, and media campaigns to educate people on how COVID-19 can be spread. The most effective way to prevent long-COVID is to prevent COVID-19 infections from the onset. It is imperative that the City Council continue to recognize the continued threat that COVID-19 poses on Latinos and all New Yorkers and ensure residents are aware of this threat and how to access medical care to treat symptoms.

I thank you for your time and continued efforts to combat COVID-19 for our entire city. Together we can empower Latinos and all New Yorkers to live healthy lives.

Testimony of Housing Works
before
The New York City Council Committee on Hospitals
and
Subcommittee on COVID Recovery & Resiliency
regarding
Long-Term COVID Treatment in New York City Hospitals
June 27, 2022

Thank you, Chairpersons Narcisse and Moya, and the Committee on Hospitals and Subcommittee on COVID Recovery and Resiliency for the opportunity to present this written testimony on behalf of Housing Works, a healing community that provides a range of integrated medical, behavioral health, housing and support services for over 15,000 low-income New Yorkers annually, with a focus on the most vulnerable and underserved—those facing the challenges of poverty, homelessness, HIV, mental health issues, substance use disorder, other chronic conditions, and incarceration.

Housing Works submits this testimony on behalf of the people we serve, to urgently appeal to the Council to exercise your oversight authority to ensure that the City's response to the needs of New Yorkers experiencing the post-acute symptoms of SARS-CoV-2 infection known as "long COVID" does not perpetuate the unconscionable health inequities that have characterized our COVID crisis to date.

Housing Works has seen close up the well-documented COVID health disparities experienced by low-income New Yorkers, especially members of Black, Indigenous, and people of color (BIPOC) communities. Housing Works operates four Federally Qualified Health Centers (FQHCs) located in medically underserved NYC communities. Eighty-four percent (84%) of the over 8,000 patients seen by our FQHCs in the last year are Black (52%) or Latinx (32%), almost 90% live below 150% of the Federal poverty level, 41% are experiencing homelessness, and 17% are uninsured. In addition, Housing Works is grateful to have had the opportunity to operate a Department of Homeless Services (DHS) COVID isolation hotel that has hosted over 2,500 guests since it opened in April 2020, and to provide medical and behavioral health care for residents of other DHS COVID hotels and of hotels operated by the NYC Mayor's Office of Criminal Justice (MOCJ) to provide an alternative to congregate shelters for people homeless upon release from incarceration.

Ample evidence supports our own sad experience that members of the communities we serve face significantly heightened risk of severe COVID-19 disease and mortality. An analysis conducted by the Coalition for the Homeless in collaboration with researchers at New York University found that through the end of February 2021, the age-adjusted mortality rate due to COVID 19 among sheltered homeless New Yorkers was 49% higher than the overall NYC mortality rate.[1] A large-scale analysis by the New York State Department of Health found that people with HIV diagnosed with COVID-19 died at a rate 2.55 times the rate in the non-HIV positive population.[2]

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[1] https://www.coalitionforthehomeless.org/age-adjusted-mortality-rate-for-sheltered-homeless-new-yorkers/
[2] Tesoriero JM, et al. COVID-19 Outcomes Among Persons Living With or Without Diagnosed HIV Infection in New York State. *JAMA Netw Open*. 2021;4(2):e2037069. Published 2021 Feb 1. DOI: 10.1001/jamanetworkopen.2020.37069

Indeed, there is currently an urgent need for the City's Department of Health and Mental Hygiene (DOHMH) to issue strong and clear guidance that people with HIV diagnosed with COVID-19 receive Paxlovid and continue their HIV antiretroviral therapy (ART) while taking Paxlovid.[3] We understand that there is confusion among New York City physicians that has resulted in some providers refusing to prescribe Paxlovid for people with HIV. In light of the known risk of severe COVID disease among people with HIV, this mistaken understanding must be corrected immediately.

Despite consistent evidence of the disparate impact of the COVID pandemic on low-income, BIPOC New Yorkers, every aspect of our COVID response to date continues to leave members of these communities behind – testing, prevention, vaccination, and access to new therapies – resulting in disproportionally high levels of infection, severe disease, and mortality.

Inadequate access to COVID-19 testing in BIPOC communities has persisted throughout the epidemic, with authors of a September 2021 NYC study in NYC reporting that "racial disparities in access to [COVID-19] testing remain as of today, despite the need for testing in communities that experience a large number of essential workers living in crowded realities."[4]

Due to pre-COVID health disparities, BIPOC individuals in New York experiencing disproportionately higher rates and severity of conditions such as heart disease and diabetes,[5] which are two of the most common underlying medical conditions that place patients with COVID-19 at increased risk for severe illness or death.[6] Not surprisingly, BIPOC communities have disproportionately higher rates of severe illness from COVID-19.[7] As of March 2021, the COVID-19 hospitalization rate of Asian Americans, Latinx, and Black New Yorkers was 2.5, 3.8, and 4.2 times that of white New Yorkers, respectively.[8]

Yet, despite experiencing higher rates of severe illness and death from COVID-19, BIPOC patients were less likely than white patients to receive monoclonal antibody therapies (mAb), with one large-scale study that included several healthcare facilities in New York finding that Latinx, Black, Asian American, and other patients of color received mAb 58%, 22%, 48%, and 47% less often, respectively, than white patients.[9] The study concluded that, "as a consequence of [BIPOC people's] higher prevalence of preexisting conditions," the mAb treatment inequity "amplif[ies] the increased risk for severe COVID-19–associated outcomes, including death among these groups."[10]

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[3] See Paxlovid for the Treatment of COVID-19: Considerations for People With HIV and Hepatitis C

[4] Wil Lieberman-Cribbin et al., *Analyzing disparities in COVID-19 testing trends according to risk for COVID-19 severity across New York City*, 21 BMC Pub. Health 1717, at 5 (2021), bit.ly/3BKU0CZ.

[5] CDC, *Prevalence of Both Diagnosed and Undiagnosed Diabetes*, bit.ly/3s3Xiwu (last reviewed Dec. 29, 2021); Gbenga Ogedegbe et al., *Assessment of Racial/Ethnic Disparities in Hospitalization and Mortality in Patients With COVID-19 in New York City*, JAMA Network Open, Dec. 4, 2020, bit.ly/3uRdjZB, at 5; Kamyar Arasteh, *Prevalence of Comorbidities and Risks Associated with COVID-19 Among Black and Hispanic Populations in New York City: An Examination of the 2018 New York City Community Health Survey*, 8 J. Racial & Ethnic Health Disparities 863–69 (2021), doi.org/10.1007/s40615-020-00844-1.

[6] *See* CDC, *People with Certain Medical Conditions*, bit.ly/3IUxx8D (updated Feb. 25, 2022); Erin K. Stokes et al., *Coronavirus Disease 2019 Case Surveillance - United States, January 22-May 30, 2020*, 69 MMWR 759 (2020), https://bit.ly/3gVs4Cv.

[7] *See, e.g.*, Anna M. Acosta et al., *Racial and Ethnic Disparities in Rates of COVID-19–Associated Hospitalization, Intensive Care Unit Admission, and In-Hospital Death in the United States From March 2020 to February 2021*, JAMA Network, Oct. 21, 2021, bit.ly/36otGCW.

[8] *See* COVID Tracking Project, The Atlantic, *New York: All Race & Ethnicity Data*, bit.ly/3sxag62 (last visited June 15, 2022).

[9] Jennifer L. Wiltz et al., *Racial and Ethnic Disparities in Receipt of Medications for Treatment of COVID-19 — United States, March 2020–August 2021*, 71 MMRW 96, 96 (2022), bit.ly/3scQRal.

[10] *Id.* at 100.

The vaccine rollout in NYC was also "plagued by stark racial disparities, with Black and Latino residents receiving far fewer doses than white residents."[11] It is dismaying, yet sadly not surprising, that as of June 5, 2022, the age-adjusted death rate from COVID-19 of Black New Yorkers is more than double that of white New Yorkers.[12]

Housing Works is deeply concerned that this history of persistent disparities is repeating itself in the case of long Covid,[13] resulting in continued harm to low-income BIPOC communities. There is reason to believe that the communities Housing Works serves will be disparately impacted by long COVID symptoms. Recent research found significantly higher rates of long COVID among people with HIV, after controlling for other factors understood to impact COVID outcomes.[14] And most of the residents of our DHS isolation hotel arrived with multiple serious untreated or undertreated chronic conditions of the type believed to leave persons more vulnerable to long COVID symptoms.

We must look honestly at the core factors contributing to COVID-19 health disparities so that we can take action to mitigate their ongoing impact. Certainly, concerted efforts are needed to continue to improve access in BIPOC communities to COVID testing, uptake of vaccination and boosters, and existing and new treatments such as Paxlovid. Testing is the essential first step required for diagnosis and treatment of long COVID symptoms, and while relatively little is known about post-acute COVID-19 complications, it is believed that vaccination and treatment to mitigate acute disease reduce the likelihood, length, and severity of long COVID.

Even more importantly, however, we must begin to address the systemic problems with our health system that limit the availability and quality of health care for members of low-income BIPOC communities. I will outline here a few steps that Housing Works believes are essential to improve COVID-19 prevention and acute care, and to develop an effective long COVID response.

Improve data collection and disaggregation to better inform the COVID 19 response.

High-quality data, disaggregated by race, ethnicity, age, and other characteristics, is essential to a "learning" health system that is able to understand, effectively respond, and fine tune the COVID response. Especially given our limited knowledge of long COVID, we simply don't know whether and to what extent the ethnic and racial inequalities observed in acute COVID-19 will be repeated or even worsened as the disease becomes chronic.

We still do not have the accurate and detailed data needed to fully understand and most effectively respond to acute COVID-19. Studies have already found that Black and Latinx people experience higher rates of certain serious COVID-19 related complications than white individuals.[15] Unless we

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[11] Emma G. Fitzsimmons, *Black and Latino New Yorkers Trail White Residents in Vaccine Rollout*, N.Y. Times (Sept. 29, 2021), nyti.ms/34JRD7m.

[12] *See* N.Y. State Dep't of Health, *COVID-19 Fatalities Tracker*, on.ny.gov/3HlNh4j (providing link to age-adjusted death rates by race/ethnicity in New York State); *see also* nychealth/coronavirus-data, GitHub, https://bit.ly/35p3k34 (displaying age-adjusted hospitalization and death rates by race).

[13] https://www.statnews.com/2021/05/10/with-long-covid-history-may-be-repeating-itself-among-people-of-color/

[14] *Post-acute sequelae and adaptive immune responses in people living with HIV recovering from SARS-COV-2 infection*, Michael J Peluso, et al. medRxiv 2022.02.10.22270471, doi: https://doi.org/10.1101/2022.02.10.22270471, https://www.medrxiv.org/content/10.1101/2022.02.10.22270471v1

[15] CDC, *Disparities in Hospitalizations*, bit.ly/3ufveJj (last updated May 23, 2022); Jamie S. Hirsch et al., *Acute kidney injury in patients hospitalized with COVID-19*, 98 Kidney Int'l 209, 210, 211 (2020), bit.ly/3sO3ZTP.

systematically measure inequalities in the experience of long COVID by race, ethnicity, and other key factors, they will remain invisible and therefore unactionable, and poor outcomes may be attributed to individual rather than structural determinants. This is of particular concern among members of vulnerable communities who often lack access to quality care and face heightened burdens to convincing providers that their conditions are real.

A related concern is the failure to date to ensure that observational studies of long COVID and treatment trials include a truly representative sample of affected individuals that includes members of disproportionately affected BIPOC, API, and LGBTQ+ communities, essential workers who may require assistance in order to find the time and resources to participate, and persons with no or limited connection to established health systems.

Acknowledge and address our history of disinvestment in health care delivery in BIPOC communities.

Racial and ethnic disparities in COVID vulnerability and outcomes are grounded in our country's long history of racist policies—such as segregation and persistent inequities in housing, employment, access to healthcare, and other life opportunities—with certain groups historically marginalized by systems and structures.[16] These societal conditions, or social drivers of health, can and do affect an individual's health risk.[17] At the same time, racism and implicit bias within the medical system has resulted in lower quality healthcare for BIPOC individuals.[18] These systemic inequities manifest as an increased risk of infection and of severe COVID-19 symptoms relative to whites that is independent of other immediately observable information such as age, vaccination status, and presence of underlying medical conditions.[19]

In New York, numerous policies over the past several decades have resulted in underfunded and under-resourced hospital systems in communities of color.[20] For example, when the state "cut thousands of hospital beds" in 2016, a disproportionate number were in communities that served people of color and underinsured individuals, exacerbating the COVID-19 pandemic's impact on those communities.[21]

A lack of health planning and reliance on a market-driven health system have over the years enabled the movement of key hospital resources to white suburban areas with commercially insured residents, while draining resources from BIPOC communities and areas with many uninsured residents and Medicaid recipients. New York State and City must specifically acknowledge the resulting inequities and commit to a wholesale review of state policies and processes that have

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[16] *See, e.g.*, CDC, *Health Equity Considerations and Racial and Ethnic Minority Groups*, bit.ly/3giQc1z (last updated Jan. 25, 2022); Paula Braveman et al., *What is Health Equity?*, Robert Wood Johnson Found. (May 1, 2017), rwjf.ws/3Gkedjx; Rima A. Afifi et al., *'Most at risk' for COVID19? The imperative to expand the definition from biological to social factors for equity*, 139 Preventive Med. 106229 (2020), bit.ly/3oYJPFx.

[17] *See* CDC, *Social Determinants of Health: Know What Affects Health*, bit.ly/3IWQXd3 (last reviewed Sept. 30, 2021).

[18] *See* Kevin B. O'Reilly, *AMA: Racism is a threat to public health*, Am. Med. Ass'n (AMA) (Nov. 16, 2020), bit.ly/35xEoGE.

[19] *See* Rima A. Afifi et al., *'Most at risk' for COVID19? The imperative to expand the definition from biological to social factors for equity, 139 Preventive Med. 106229 (2020), bit.ly/3oYJPFx.*; Benjamin Seligman et al., *Social determinants of mortality from COVID-19: A simulation study using NHANES*, PLOS Med., Jan. 11, 2021, bit.ly/3ITbxek.

[20] Amanda Dunker & Elisabeth Ryden Benjamin, *How Structural Inequalities in New York's Health Care System Exacerbate Health Disparities During the COVID-19 Pandemic: A Call for Equitable Reform*, Cmty. Serv. Soc'y (June 4, 2020), https://bit.ly/3KZ7JtZ.

[21] David Robinson, *Why NY hospital closures, cutbacks made COVID-19 pandemic worse*, Times-Herald Record (Apr. 10, 2020), bit.ly/3snDN1W.

perpetuated disparities and poor health for people of color, people with disabilities, and other underserved and marginalized communities.

This is critical in light of the recent movement towards the creation of specialized clinics to care for long COVID patients. Certainly, there is a role for H+H and other centers of excellence that bring together specialists in various disciplines and engage in long COVID research and drug trials. We must be careful, however, to not repeat the creation of segregated crisis response systems that have not worked in the past, result in siloed funding streams, and are unlikely to reach persons excluded from or marginal to large health systems. As just one example, the CDC identified several access-related and systemic factors as potential explanations for the documented racial and ethnic inequities in COVID-19 mAb treatment.[22]

Recognizing the access-related and systemic factors that contribute to COVID and other health inequities, we believe that it will be essential to strengthen and support the ability of existing services to respond to long COVID, especially ambulatory primary care.

Center primary care in the response to long COVID.

Creating special systems to address emergencies can result in lack of investment or even disinvestment in the primary care systems that Housing Works believes are uniquely positioned to identify long Covid in vulnerable patients and provide and coordinate ongoing care.

Neighborhoods with high rates of COVID-19 infections and poor primary care access are low-income BIPOC communities that experience higher rates of the chronic diseases that increase COVID vulnerability and are best managed by primary care providers.[23]

A primary care physician may be more likely to treat patient reports of post-acute COVID symptoms as credible and/or may know the patient well enough to recognize the need for specialty care. Racial concordance between patient and clinician also contributes to trust. Low-income patients may lack the time and resources to travel to a specialized clinic.

As noted in a recent analysis, "there is an argument for resourcing whole-patient primary care support rather than (or in addition to) providing ring-fenced funding solely for long COVID." A primary care provider who "knows the patient and his or her life circumstances is in an optimal position to coordinate and personalize the recovery plan and understand the barriers the patient faces while struggling to follow it." The authors note that "A comprehensive training program for generalist clinicians, along with care pathways, guidance, and criteria to which patients should be referred, must underpin a primary care–led long COVID response. A diversified health care workforce, greater cultural humility, and fewer health inequities are part and parcel of this effort, considering the role of racial injustice in long COVID."[24]

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[22] Wiltz JL, et al. Racial and Ethnic Disparities in Receipt of Medications for Treatment of COVID-19 — United States, March 2020–August 2021. MMWR Morb Mortal Wkly Rep 2022;71:96–102. bit.ly/3scQRal

[23] Primary Care Dev. Corp., *To Address COVID-19 Disparities, PCDC Urges New York State to Invest in Primary Care* (June 1, 2020), bit.ly/3s18Sts.

[24] Berger Z, Altiery De Jesus VV, Assoumou SA, Greenhalgh T. Long COVID and Health Inequities: The Role of Primary Care. *Milbank Q. 2021;99(2):519-541.* https://doi.org/10.1111/1468-0009.12509

Support the key role of community-based organizations.

An effective and equitable response to long COVID will also require an interdisciplinary approach and workforce with the ability to address physical, psychological, and social impacts. COVID-19 and its long-term sequelae are strongly influenced by social determinants such as poverty and by structural inequalities such as racism and discrimination. An individual's work conditions, access to healthcare, exposure to racism, and segregated living conditions often go hand in hand, leading to a cumulative increase in risk of severe illness or death from COVID 19, contributing to BIPOC peoples' disproportionate rates of severe illness and death from COVID-19, across the country and in New York.[25]

The prolonged impacts of long COVID will require renewed and new efforts to identify long COVID and ensure access to the survival services required to support access to effective care. The follow-up and treatment of prolonged multisystemic systems will vastly increase health care costs, particularly for uninsured or underinsured persons. Meanwhile, debilitating and perhaps disabling symptoms may interfere with people's ability to work and generate income for themselves and their families. Vulnerable persons have less job security and flexibility, and less entitlement to sick pay and health services.

Extremely poor persons may lack the safe housing and adequate nutrition that provide the essential baseline for managing any chronic illness. Through our work over the past two years providing COVID isolation and quarantine services for New Yorkers experiencing homelessness, Housing Works has come to deeply appreciate how awful and dehumanizing the City shelter system is, and the urgent need to radically rethink our response to homelessness, especially among people with acute and chronic health needs.

CBOs have been doing the work to address social determinants of health, particularly in medically underserved communities, for decades. CBOs provide culturally and linguistically tailored interventions, are able to access and have trusted relationships with hard-to-reach populations, and deliver the services necessary to address unstable housing, food insecurity, lack of childcare, and other social factors impacting health. However, unequal power dynamics often leave CBOs on the outskirts of health planning processes and inadequately funded to scale essential programs and services.

Housing Works is part of Communities Driving Recovery, a community and faith-based alliance of organizations seeking to ensure a just pandemic recovery by continuing to build upon the demonstrated impact of CBOs working together with city health officials to tackle the devastating disruptions to public health and neighborhood stability during the pandemic. As we seek answers to address the glaring COVID 19 health disparities and the complications presented by the prolonged impacts of long COVID, we need to ensure that we continue to build on a community-based model of service delivery that has been shown to be most effective in reaching vulnerable

[25] *See, e.g.*, Ankur K. Dalsania et al., *The Relationship Between Social Determinants of Health and Racial Disparities in COVID-19 Mortality*, 9 J. Racial & Ethnic Health Disparities 288, 294 (2021), bit.ly/3h0hqdT; Nicholas Verdini et al., *Social Determinants of Health Amplify the Association Between Ethnicity and COVID19: A Retrospective-Cohort study*, 9 Int'l J. Med. Students 282, 282 (2022), doi.org/10.5195/ijms.2021.1125; Sarah B. Maness et al., *Social Determinants of Health and Health Disparities: COVID-19 Exposures and Mortality Among African American People in the United States*, 136 Pub. Health Reps. 18, 18 (2020), bit.ly/3LJyuCP; Rienna G. Russo et al., *COVID-19, Social Determinants of Health, and Opportunities for Preventing Cardiovascular Disease: A Conceptual Framework*, J. Am. Heart Ass'n, Dec. 10, 2021, doi.org/10.1161/JAHA.121.022721.

communities. Meeting this challenge will require payment models that appropriately compensate CBOs for their work, including adequate compensation for front-line human services workers.

Ensure participation of affected communities on advisory boards and other government bodies charged with planning and oversite.

Finally, it is critical to an effective and equitable long COVID response to ensure community-based providers and members of affected communities are represented on stakeholder bodies responsible for planning, recommendations, and oversight of the City's response to long COVID. To date, community committees and subgroups convened to advise government on COVID 19, including the challenges posed by long COVID, have been highly clinical in their composition. Comprehensive and effective planning and oversight will require representation from affected communities and reflecting the multidisciplinary approaches necessary for an equitable and effective NYC response.

Conclusion

In summary, Housing Works strongly believes that COVID-19 and its long-term sequelae are strongly influenced by social determinants such as poverty and by structural inequalities such as racism and discrimination. We urge the Council to acknowledge and address the lack of investment in our health systems that undermine access to quality healthcare by the most vulnerable New Yorkers, and to support primary care providers that are uniquely positioned to provide and coordinate care for vulnerable patients with long COVID. Key policy measures must include optimizing data quality, strengthening primary care, and concrete action to address the multiple social and structural determinants of health inequities that have been newly exposed by the COVID crisis, including racism and implicit bias, as well as lack of access to basic necessities such as safe housing, a living wage, and food security. To advance these priorities, we urge NYC to ensure convene planning and oversight bodies that fully represent all stakeholders. Housing Works believes that failure to take these steps will result in the unconscionable perpetuation of the avoidable health inequities we work to understand and mitigate the effects of long COVID.

Please contact ***Anthony Feliciano***, Housing Works Vice President for Community Mobilization, with questions or additional information. He can be reached at a.feliciano@housingworks.org or 929-617-5637.

Oversight Hearing of the Committee on Hospitals jointly with
The Subcommittee on COVID Recovery and Resiliency
Long-Term COVID Treatment in New York City Hospitals
June 27, 2022

Testimony of Annabelle Ng, Health Policy Associate
The New York Immigration Coalition

My name is Annabelle Ng, and I am the Health Policy Associate at the New York Immigration Coalition (NYIC). We thank the Chairs and Council Members of the Committee on Hospitals and Subcommittee on COVID Recovery and Resiliency for the opportunity to testify today.

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. Our members serve communities that speak more than 65 languages and dialects. I want to talk about immigrant access to long-term COVID treatment.

As researchers continue to uncover the effects of COVID-19 on one's health and why certain individuals develop post-COVID conditions, it is clear that COVID-19 can cause a wide range of ongoing health problems that may last long after an individual has been infected with the virus. Among many concerning findings, researchers have reported that even a mild case of COVID-19 can increase a person's risk of cardiovascular problems such as heart failure and stroke. In this study, heart-disease risk was higher even for those who were under 65 years of age and lacked risk factors such as obesity or diabetes. The debilitating symptoms of long COVID are not only physical but also mental–for example, a BMC Psychiatry study found that people with post-COVID conditions were twice as likely to develop mental health issues such as depression, anxiety, or post traumatic stress disorder as people without them. Another study found that COVID-19 survivors were almost 50% more likely to experience suicidal ideation than people who hadn't had the virus.

Long COVID has affected our communities and myself personally. For almost a year following a relatively mild case of COVID, I experienced fatigue and parosmia–a condition that made almost all food smell and taste unpleasant. It became difficult for me to eat and get through my day, and because my doctor had no information about how my symptoms could be treated, I was told to simply wait it out. Many others have suffered from more severe psychiatric, neurological,

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and physical illnesses, as well as inflammatory brain damage, that render them unable to work, go to school, or live their daily lives. Furthermore, just as low-income individuals, immigrants, and people of color have suffered disproportionately from the pandemic and inequitable COVID testing and vaccination, these communities will continue to experience significant barriers to accessing culturally appropriate long-term care, especially for conditions that are still not fully understood.

Immigrant New Yorkers in particular have suffered reduced access to health services throughout the pandemic because of the state's persistent health insurance discrimination against those without status. While the New York State Fiscal Year 2023 budget ensured 12 months of continuous post pregnancy coverage for everyone, regardless of status, and allowed undocumented immigrants age 65 and over to access Medicaid for the first time, many immigrants still lack access to the long-term care that is required to manage post-COVID conditions.

In order to improve access to care for the hundreds of thousands of New Yorkers without health insurance, NYC Care has directed many of these individuals to much-needed low-cost primary and preventive care as well as specialty services. We are encouraged by the continued partnership with community-based organizations to conduct NYC Care-specific outreach and the elimination of the six-month residency eligibility requirement, which enables more New Yorkers living in the five boroughs to access this program.

We urge NYC Health + Hospitals and City Council, in its oversight role, to ensure that all low-income, immigrant COVID long-haulers can receive long-term care. We cannot achieve true, equitable recovery from the COVID-19 pandemic without addressing both physical and mental health needs of vulnerable communities and providing coverage for ALL New Yorkers regardless of their immigration status.

Thank you for the opportunity to submit this testimony.

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Testimony of the New York Civil Liberties Union Before the New York City Council Committees on Health and Hospitals

Regarding

Oversight: Maternal Health, Mortality, and Morbidity

June 29, 2022

The New York Civil Liberties Union (NYCLU) is grateful for the opportunity to submit the following testimony regarding maternal health, mortality, and morbidity. The NYCLU, the New York State affiliate of the American Civil Liberties Union, is a not-for-profit, nonpartisan organization with eight offices across the state and over 180,000 members and supporters. The NYCLU defends and promotes the fundamental principles and values embodied in the Bill of Rights, the U.S. Constitution, and the New York Constitution through an integrated program of litigation, legislative advocacy, public education, and community organizing. The NYCLU supports legislation under consideration by these Committees that improves access to non-discriminatory health care and provides these comments on the bills and resolutions on the agenda today.

The NYCLU strongly supports improving access to the full spectrum of quality reproductive and pregnancy-related health care that empower people to make decisions about their lives, bodies, and families. Especially in the wake of the *Dobbs v. Jackson* decision overturning *Roe v. Wade*, New York must affirm pregnant people's bodily autonomy and right to receive safe and respectful care of their choosing. Collectively, the measures before the committee advance this objective by expanding patients' access to information and modalities of care so they are empowered to make the health care decisions that are right for them.

As New York positions itself as an access state for people around the country seeking reproductive care, the city must ensure it supports care that is accessible, patient-centered, and culturally competent. Even before the *Dobbs* ruling, reproductive

freedom and bodily autonomy remained a fiction for many pregnant people—especially those who are Black, Brown, Latinx, immigrant, and/or low-income. In New York City, Black maternal mortality rates remain startlingly high,[1] and pregnant people are frequently drug tested without their consent[2] and even forced to receive medical procedures against their will.[3] The bills before the committees today are much-needed steps toward empowering patients, improving outcomes, and reducing disparities.

In particular, expanding access to community-based doulas is a key step New York City can take to improve reproductive health care experiences. Doulas are associated with improved maternal health outcomes and lower rates of medical intervention in birth.[4] They can also play a role in combatting discrimination and bias in health care settings by advocating for their patients, while fostering their sense of power, autonomy, and trust.[5]

Additionally, the NYCLU hopes that Int. 0086, providing for public education about pregnant patients' rights, including the right to be free from discrimination related to their pregnancy status, will improve the tenor of interactions between patients and providers, and promote respect, autonomy, and patient-centered care.

The measures before the committees today represent important steps forward at a time of devastating national regression. The NYCLU is grateful for the Council's commitment to working towards reproductive health, justice, and equity, and is eager to continue to collaborate with you in support of these and future efforts.

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[1] In 2017, the most recent year for which data is available, Black mothers gave birth to 23% of New York City newborns, yet accounted for 55% of maternal deaths. Public Advocate Jumaane Williams, *NYC Public Advocate Releases Report on Maternal Health Inequities* (Nov. 11, 2021), https://pubadvocate.nyc.gov/press/nyc-public-advocate-releases-report-maternal-health-inequities/#:~:text=In%202017%2C%20Black%20women%20gave,insurance%20or%20socio%2Deconomic%20status; *see also* Public Advocate Jumaane Williams, *White Paper: Equitable Pregnancy Outcomes for Black and Brown New Yorkers* (2021), https://files.constantcontact.com/1c58f85b001/12ddd072-50eb-45ec-8bb7-28ab09ed45ce.pdf?rdr=true.

[2] *See* NYC Commission on Human Rights, *New York City Commission on Human Rights Launches Investigations Into Three Major Private Hospital Systems' Practices of Drug Testing Newborns and Parents*, Press Release (Nov. 16, 2020), https://www1.nyc.gov/assets/cchr/downloads/pdf/press-releases/Hospitals_Press_Release_11-16-2020.pdf.

[3] *Dray v. Staten Island Univ. Hosp.*, 74 N.Y.S.3d 69 (2018); See also National Advocates for Pregnant Women, *Rinat Dray Decision Proves How Hard it is for Women Subjected to Forced Surgeries to Get Justice* (Apr. 23, 2018), https://www.nationaladvocatesforpregnantwomen.org/rinat-dray-decision-proves-hard-women-subjected-forced-surgeries-get-justice/.

[4] Nora Ellmann, *Community-Based Doulas and Midwives: Key to Addressing the U.S. Maternal Health Crisis*, Center for American Progress (Apr. 14, 2020), https://www.americanprogress.org/article/community-based-doulas-midwives/.

[5] Id.

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ATTN:

New York City
City Council
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New York, NY 10007

Dear City Council Members,

My name is Caroline Stephenson, and I'm submitting this as my written testimony for the June 24th, 2022 Hearing of the Committee on Education.

I have a daughter finishing second grade at PS 40 in District 2, and was shocked to hear about the cut to the education budget pushed through by Mayor Adams. As I have watched public education being kneecapped by conservatives around the country, I never imagined our own Mayor would betray this pillar of American society in the same way. **I ask that we roll over unused stimulus funding from 2022 to cover core school budgets in 2023.**

Furthermore, funding the school system by enrollment makes ZERO sense. We should be looking at what schools need, especially to **hold into every single teacher**, and then making sure we fund them at that level. Can we get rid of 12% of a building that needs to be maintained? If a class is 12% smaller, do we need to spend 12% less time teaching them? Can we fire 12% of a teacher? Drop 12% of an enrichment program? The only outcome possible is making our schools offer less to the remaining students, at a time when **they need us more than ever**.

We have the money; we can afford to invest in our children. **We should be leading the country in educational excellence**; how can we have pride in a city that knows we could do better, but instead chooses to degrade the schools and pinch pennies at a time of record revenues? I am ashamed to be New Yorker today, something I have NEVER felt since the day I was born in this miraculous city.

Our children are **behind academically, socially, and emotionally** after two years of disrupted learning. And let's not pretend that our public school system was in the best of health before COVID. To cut funding at this time:

- Removes additional services to help children recover from the pandemic.
- Will increase racial and economic educational inequality.
- Increases the chance that some families will pull their children from public school, or choose not to enroll them in the first place, accelerating a self-reinforcing spiral of downward enrollment that may not be reversible.
- Makes decreasing class sizes impossible.
- Increases the chance of losing even more teachers, as their work load increases and the stress burns them out.

We have a choice right now between setting a better course for our future, or taking the resources that the next generation needs for our own short-sighted political purposes. I implore you to do the right thing.

Sincerely,

Caroline Stephenson

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 6/27/22

(PLEASE PRINT)

Name: Ted Long

Address: 50 Water St

I represent: NYC H+H

Address: 50 Water St

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Celia Quinn

Address: NYC DOHMH

I represent: Deputy Commissioner, Disease Control

Address:

Please complete this card and return to the Sergeant-at-Arms