CITY COUNCIL
CITY OF NEW YORK

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TRANSCRIPT OF THE MINUTES

Of the

COMMITTEE ON HOSPITALS JOINTLY WITH
THE COMMITTEE ON HEALTH

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September 30, 2020
Start: 10:10 a.m.
Recess: 1:07 p.m.

HELD AT: REMOTE

B E F O R E:

CARLINA RIVERA
Chairperson

MARK LEVINE
Co-Chairperson

COUNCIL MEMBERS:

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

Doctor Theodore Long
Executive Director and Vice President
Ambulatory Care at NYC Health and Hospitals

Jackie Bray
Deputy Executive Director
Test and Trace Corps

Annabel Palma
Chief Equity Officer
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Doctor Andrew Wallach
Chief Medical Officer
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Doctor Niel Vora
Director of Tracing
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Doctor Amanda Johnson
Director of Isolation
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Doctor Demetre Daskalakis
Deputy Commissioner of Disease Control
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New York Doctors Coalition

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Max Hadler
Director of Health Policy
New York Immigration Coalition

Hayley Gorenberg
Legal Director
New York Lawyers for the Public Interest

Anthony Feliciano
Director
Commission on Public's Health System

Thank you. Sergeant Biallo [sp?] would you begin with your opening statement Sir?

SERGEANT: Yes Sir. Good morning everyone and welcome to today's remote New York City Council Hearing on the Committees on Hospitals jointly with the Committee on Health. At this time would all panelists please turn on their video. Once again, all panelists please turn on your videos for verification. Thank you. If you wish to submit testimony you may do so at testimony at council dot NYC dot gov. Once again, that is testimony at council dot NYC dot gov. Thank you very much for your cooperation. Chairs, we are ready to begin.

CHAIRPERSON RIVERA: Okay great. Thank you so much. Good morning everyone.

[gavel]

CHAIRPERSON RIVERA: Thank you for joining our virtual hearing today held by the Committee on Hospitals and the Committee on Health on New York City's Covid-19 testing and contact tracing program. My name is Carlina Rivera. I am the Chair of the Committee on Hospitals. I'd like to start by thanking my colleague Council Member Mark Levine for chairing this hearing with me today. I'd also like to thank

all of you who have joined us for this hearing. We are here today to examine the city's Covid-19 testing and contact tracing program otherwise known as the T2 program. This pandemic is unlike anything we have ever seen before and has caused immeasurable hardship for our city. It has highlighted longstanding inequities based on race, socioeconomic status, religion, and immigration status which impact the health and financial stability of several communities. In order to protect New Yorkers and reduce the spread of Covid-19 as much as possible we must have a robust, trustworthy, and culturally inclusive contact tracing program. Contact tracing encompasses several important responsibilities such as investigating cases, tracing and monitoring contacts who have potentially exposed to Covid-19 and ensuring individuals who are required to quarantine or isolate have access to resources and wrap around services as needed. According to its website the contact tracing program relies on partnerships with community based organizations, local providers, and nonprofits to provide culturally and linguistically appropriate services and respond to the needs of communities that have disproportionally affected by

the Covid-19 pandemic. Today we will build off our first T2 hearing held back in May where we would discuss our concerns with shifting contact tracing responsibilities from DOHMH to H&H as well as concerns about community buy in and trust. We will examine the implementation of T2 and how well the program has enlisted the help of community based organizations in their efforts to meet the needs of this city's incredibly diverse community. It cannot be stated any clearer. The only way we will have a successful program and therefore protect New Yorkers to the best of our abilities is if the T2 program has meaningful partnerships with CBOs and other community leaders. Many of our city's CBOs and community leaders have trusted relationships with our city's most vulnerable community and this trust cannot be built overnight. The importance of such relationships is highlighted by our current situation. We are currently seeing spikes in cases and for the first time in months yesterday we reported a positivity rate of over three percent. This is incredibly concerning to me. While I know the city is now acting to ensure the communities experiencing spikes are receiving the resources they need and that they are

performing meaningful outreach it feels as if our response has been too reactionary. We should be proactively ensuring spikes such as the ones we are seeing now never happen. CBOs and community leaders are able to anticipate the needs of their communities. They do not just react to their needs. This is the expertise we should have been utilizing all along as we had emphasized back in May. Covid cases and deaths are avoidable and we cannot continue to let our most vulnerable communities suffer. If community involvement and education is not improved more lives will be put on the line. If we do not strengthen our responses we will continue to see devastating impact of Covid-19 on communities who have been subjected to inequities and marginalization for years. I am interested in learning about the program's collaboration with CBOs including those which may be smaller and have less resources compared to others. I am also particularly concerned about language access and whether we are reaching traditionally hard to reach communities in their language and with appropriate messaging. For example, due to privacy concerns we are unsure precisely how many contact tracers are fluent in African, American

Sign Language, Farci, German, Japanese, Korean, Malay, Polish, Punjabi, and Yiddish. There have been reports that while there is a contact tracing advisory board composed of community leaders it seems as if their concerns specifically related to data privacy have been ignored. This is particularly concerning since mistrust among communities of color and others is related to a historical legacy of mistreatment and discrimination which have been extended to policies under this federal administration. We're also concerned about T2 data. In May 2020 the council passed introduction number 1961-2020 regarding public reporting on contact tracing for Covid-19. While the data provided by the T2 program has improved over time there is still incomplete data in reporting that can be clarified. For example, demographic data can be improved since many people do not report their race or ethnicity. For data to accurately identify harder hit populations and communities it is essential that it is both complete and disaggregated by all demographic categories which it is currently not. I look forward to addressing our concerns and learning more about the work of the T2 program. I also look forward to

hearing from advocates about their experiences interacting with T2 as well as the experiences of their clients. I want to thank the members of the administration for here testifying today. H&H and DOHMH have been working tirelessly for months to protect all of us. While I understand the incredibly hard work that Doctor Long and others present have put into the T2 program I know that we all agree that we must work together to ensure the success of the program. So today we, we can see if there are better ways for us all to collaborate. Today we will also hear a resolution, resolution 0638-2018 calling on the New York City Department of Health to create standalone, self-contained isolation centers or units for the treatment of patients with infectious disease due to epidemic including highly contagious and airborne diseases sponsored by Council Member Eugene. I look forward to hearing more from Council Member Eugene and the impact such centers would have on the health and safety of our communities in future pandemics. Thank you all again for being here and I look forward to robust discussions. I will now turn it over to my Co-Chair Council Member Levine.

COCHAIRPERSON RIVERA: Thank you so much Chair Rivera. Really pleased to be partnering with you in today's hearing on this very important topic. And pleased that we're joined by a number of colleagues including Council Member Doctor Eugene as you mentioned, Council Member Reynoso, Council Member Moya, Council Member Holden, Council Member Cohen, Council Member Maisel, and Council Member Barron as well as New York City's public advocate Jumaane Williams who we'll be hearing from momentarily. As you mentioned Madam Chair. Today is a follow up to the hearing we held on this critical program, New York City's test and trace last May, just as this program was launching. Today's hearing is taking place at a complicated moment in our battle against this virus. With cases and positivity rates rising sharply in numerous neighborhoods, to the reopening this week of our schools, the resumption today of limit to indoor dining, and colder weather arriving soon. We need a robust program of testing and contact tracing to protect our city at this difficult moment. Thankfully our testing capacity has expanded dramatically since the crisis days of last spring. And we are now doing on average over 30,000 tests per

day. And wait times have thankfully dropped significantly since August when delays of as much as 14 days for results were not uncommon. But even today all communities in our city are still not accessing tests equally. We need to do more to increase testing on the people on highest risk, the black and brown communities at highest risk, and all neighborhoods which are now seeing a spike in cases. And the rise of antigen testing has thrown us a curveball since many of these tests being done and at point of care are not being reported hindering our ability to track citywide trends. Our city's contact tracing program has also expanded significantly since our last hearing with an encouraging increase in the rate of interview completion amongst those who test positive in their contacts. Less clear is the rate of completion of and compliance with the full period of quarantine or isolation for those who test positive or have been exposed. This is a key pillar in our fight against the second wave. And we need to better understand how well it's working. Contact tracing is becoming more challenging and even more high stakes as schools, restaurants, and other indoor venues reopen. I look forward to hearing about the resources

and protocols we're applying to this growing challenge. Finally, I want to strongly echo chair Rivera in saying that in the most diverse city on earth none of this works, not the testing, tracing, or isolating unless the people doing the work have deep cultural competence, linguistic competence, authentic roots in the front lying communities most impacted, and most important of all, the trust of the people we're serving and caring for. The challenges in the current hotspots in Brooklyn and Queens indicate that we have much more work to do to meet this goal. I want to thank the administration for being here today and I look forward to a robust discussion with all of you on this critical topic. Thank you, and back to you Chairman.

CHAIRPERSON RIVERA: Thank you so much. I will now turn it over to Council Member Eugene who has prepared opening remarks.

COUNCIL MEMBER EUGENE: Thank you very much. Good morning. I want to thank Chair Rivera for her leadership of the Committee on Hospital as well as the Health Committee Chair Levine and all of my colleagues support resolution 638 and understand a dire situation that our city continues to face with

the spread of Covid-19. We all know that the, this- disease continues to cause [inaudible 12:08] to the health of, of all New Yorkers including the long term health issues. And it is important that we continue to work together and use all available resources to protect the New York City. Resolution 638 calls a New York State Department of Health to create a standalone self-contained isolation centers or units for the treatment of patient with infectious disease due to- including highly contagious disease like a Covid-19. As we so at the outset of this pandemic officials of all of government had to work expeditiously to prepare enough hospital bed for the thousand New Yorkers who, who became infected with Covid-19. We saw the [inaudible 13:00] of the USNS [inaudible 13:06] to help accommodate another floor of patients as well as a the, of the conversion of the, Davies Center into a medical facility. And even the use of Central Park as field hospital to help care for the sick. We also witnessed that the distress and agony of all healthcare workers who fought it desperately to save life in the face of uninvisible ending. We thank and commend all healthcare workers, first responders, essential

workers, and military personnel who risk their own personal health and went above and beyond the call of duty to build facilities and care for New Yorkers and get them through this horrible pandemic. At the same time we now understand what preventive measure must be taken [inaudible 14:05] of a public health emergency. The need for isolation centers is long overdue so that we can contain protect infected individuals in a more, in a more efficient manner. As a, with a any infectious disease Covid-19 can mutate and change as it is transmitted. Our country [inaudible 14:29] outbreaks of a disease in the past that we were better prepared to contend including Ebola, H1N1, and such. But we are now seeing a [inaudible 14:42] of Covid-19 in comparison to previous outbreaks. With having said that we are in a new era of infectious disease. And we must now raise a preparedness lever to better protect the [inaudible 15:00] community. As the national death toll exceeds 200,000 lives we must act with a new sense of urgency to prepare New York City for future public health emergencies. That is why it is important to create self contained isolation centers so that we can more readily isolate sick and individual without having to

overextend city and state resources in the event of a mass hospitalization. I'm confident that the creation of this new medical infrastructure will not, event this infectious disease but also have, as a city and state to be more prepared in the event of any major public health emergency or crisis. I want to thank one more time Chair Rivera and Chair Levine and all my colleagues. And I want to thank also the legislative and all my staff especially [inaudible 16:11] for the work on this- legislation. Thank you very much and Chair Rivera. Thank you Chair Levine. Thank you.

CHAIRPERSON RIVERA: Thank you so much Council Member Eugene. I will now turn it over to public advocate Williams who has also prepared opening remarks.

PUBLIC ADVOCATE WILLIAMS: Thank you so much Madam Chair. As mentioned my name is Jumaane Williams, Public Advocate for the City of New York. Again want to thank Committee on Hospitals Chair Carlina Rivera and Committee on Health Chair Mark Levine for holding today's hearing as well as Doctor Eugene for the thoughtful resolution we're hearing today as well. Since our discussion on the 15th, on

May 15th on testing and contact tracing Covid-19 still remains a threat despite the low infection rate across the city. The reason uptick in parts of Brooklyn is a testament to this and we see an uptick as a whole in the city the past few days. Too many people have lost their lives to the virus and we do not need to see more deaths in the fall that could have been avoided. That is why a clear transparent plan from the administration is needed. Countries around the world have shown us how a plan to mitigate Covid-19 can succeed. In Senegal there is a one dollar testing kit, 24 hour test results and daily and transparent reports to citizens. Officials add personal notes for each death to make sure we know more about those who have past instead of merely calculating the statistic. In South Korea officials rely on the three T's, test, trace, and treat. More with technology is used to inform citizens as well as accommodate messages based on gender, religion, region, and other factors. These are valuable lessons that I recommend for our city officials to review. In May Health and Hospitals CEO Doctor Mitchell Katz testified that his agency can work with the Department of Health and Mental Hygiene on a joint

message to the public. Three months later Doctor Oxiris Barbot resigned from her post during one of the most important health crisis in the city's history. I'd be remiss if I didn't mention what she experienced as a woman, Latina in this position for this administration was very hard to watch and deserving of its own hearing actually. With that aside in her view DOHMH was best positioned to managed contact tracing based on its history of doing so. Yet, this administration thought otherwise. I hope to hear concrete steps from both city health agencies to prevent a second wave. We also heard from Doctor Katz that Health and Hospitals can quickly higher staff, staffers, mobilize its testers, and use its resources compared to the DOHMH and yet in July we read that contact tracers come unprepared in a disorganized program. Even worse the city's testing system could not keep up with demand. This caused delays with tests. As more students return to school this is alarming. This is another subject and another data, a plan of the administration to reopen schools makes all of these other issues even worse. I appreciate that- reduce delays. However, it is clear our medical infrastructure needs improving. The

amount of personal data being stored as a part of a contact tracing program and the fact that the data is being held in an identifiable manner with no plans to destroy it or anonymize it in the future presents a real danger to the privacy and protections of constituents. Contact tracing collects personal information beyond just positive test status and date information. Reaching far in the context relations, locations, habits, and lives. With this amount of data being collected concrete plans for the protection and the removal of it should be set in place now to ensure constituents can trust and participate in the contact tracing program. When my office brought this up to the governor's office and the mayor's office the governor gave a flipped response. The initial response of the mayor was nothing at all. I am thankful the administration has had a conversation with us what they were trying to do but there's still some more that's needed to make sure that we can tell all constituents that they have nothing to worry about. So I'd like New York City testing trace calls and the administration to commit what I just mentioned, the type of process that we think is best, please commit to it today. Furthermore

I anticipate discussion on the city's plan when a vaccine appears. I agree with the mayor that we must prepare for a vaccine. Yet, the state will review vaccines approved by the federal government. I see your concerns about federal efforts to speed up the availability of the vaccine when people are rightfully apprehensive especially from this administration, federal administration that has lied and provided false information since the beginning of the pandemic. There was a public/private partnership called operation warp speed with 10 billion dollars spent so far to fast track a vaccine. There is the advisor committee on immunization practices historically in charge of informing the Centers for Disease Control and Prevention on vaccination policy yet I am worried public health experts will vary in the recommendations for the government. Outside the federal government but at the request of federal officials there was a national academy of medicines expert panel to determine the priority of distribution. There's also the national medical association all black position taskforce to vet federal decisions and recommendations on vaccines to ensure communities of more color are not forgotten.

Who will the administration listen to when vaccines are released? How confident will we be if one is released this year? In these discussions we of course must focus on the entire city but we must also center communities of more color. They suffer the most during the worst of Covid-19 early this year. DOHMH data indicates this disparities still exist. The Covid-19 case rate per 100,000 residents among black and Latin X people was about 1.5 and 1.6 times higher than white people respectfully. If there is a resurgence we cannot see these communities disproportionately impacted again. Communities of more color should be consulted in the public health strategies and conversations on testing, contact tracing, and especially a vaccine. Lastly I will say I know we all are very aware of the shortcomings of people in the white house and the federal government. But that doesn't mean that we as a city and state should not do everything we can with the power that we have to make sure we get through this. We haven't seen that as the beginning of this pandemic and I hope that that really changes and we can have full confidence. So I look forward to this hearing today. Thank you for the opportunity to speak both Chairs.

CHAIRPERSON RIVERA: Thank you Public Advocate Williams. I want to also acknowledge we've been joined by Council Member Powers and Council Member Ayala. I will now turn it over to our moderator Senior Policy Analyst Emily Balking [sp?] who will review some procedural items relating to today's hearing and call our first panel of witnesses.

SR. POLICY ANALYST EMILY: Thank you Chair Rivera. I'm Emily Balking, a senior policy analyst to the Committee on Hospitals and the Committee on Health of the, of the New York City Council. I will be monitoring today's hearing. Before we begin I want to go over a few procedural matters. I will be calling on panelists to testify. I want to remind everyone that you will be on mute until I call on you to testify. You will then be unmuted by the host. Please wait for your names to be called. For everyone testifying today please note that there may be a few seconds of delay before you are unmuted and we thank you in advance for your patience. I will be periodically announcing the next panelists. At today's hearing the first panel will be the administration followed by council member questions

and then the public can testify. During the hearing if council members would like to ask a question please use the zoom 'raise hand' function and I will call on you in order. I will now call on members of the administration to testify. Here to testify is Doctor Ted Long, The Executive Director and Vice President of Ambulatory Care at New York City Health and Hospitals. And here for Q&A from the New York City Test and Trace Corps are Jackie Bray, the Deputy Executive Director, Annabel Palma, the Chief Equity Officer, Doctor Andrew Wallach, Chief Medical Officer and Director of Testing, Doctor Niel Vora, Director of Tracing, Doctor Amanda Johnson, Director of Isolation, and here for Q&A from DOHMH is Doctor Demetre Daskalakis, the Deputy Commissioner of Disease Control. I will now administer the oath to the administration. When you hear your name please respond. Do you affirm to tell the truth, the whole truth, and nothing but the truth before this committee and to respond honestly to council member questions. Doctor Long?

DOCTOR LONG: Yes.

SR. POLICY ANALYST EMILY: Jackie Bray?

JACKIE BRAY: Yes.

SR. POLICY ANALYST EMILY: Annabel Palma?

ANNABEL PALMA: Yes.

SR. POLICY ANALYST EMILY: Doctor Wallach?

DOCTOR WALLACH: Yeah.

SR. POLICY ANALYST EMILY: Thank you. Doctor Vora?

DOCTOR VORA: Yes.

SR. POLICY ANALYST EMILY: Thank you. Doctor Johnson.

DOCTOR JOHNSON: Yeah.

SR. POLICY ANALYST EMILY: Thank you. And Doctor Daskalakis?

DOCTOR DASKALAKIS: Yes.

SR. POLICY ANALYST EMILY: Okay Doctor Long you may begin when you’re ready.

DOCTOR LONG: Okay. Good morning Speaker Johnson, Chairwoman Rivera, Chairman Levine, members of the Committee on Hospitals and Committee on Health. I am Doctor Ted Long, the Executive Director of the Test and Trace Corps and Senior Vice President for Ambulatory Care at New York City Health and Hospitals. I am joined today by the leaders of the Test and Trace Corps Jackie Bray, Deputy Executive Director and Annabel Palma, Chief Equity Officer.

Also present this morning are Doctor Andrew Wallach, Chief Medical Officer and Director of Testing, Doctor Niel Vora, Director of Tracing, Doctor Amanda Johnson, Director of Isolation or Take Care, and Doctor Demetre Daskalakis, Deputy Commissioner for Disease Control at the Health Department. Thank you for the opportunity to testify before you on New York City's plan for Covid-19 testing and contact tracing. The Test and Trace Corps launched on June 1st with an imperative to test, trace, and take care of every New Yorker who tested positive for Covid-19 or may have come into contact with someone with Covid-19. We are informed of positive Covid-19 results or cases, then we rapidly track and monitor contact for expose to Covid-19 and manage all cases and contact data. We 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 hostel and ensure their contacts are swiftly traced, assessed, and quarantined at, at home or a hotel as necessary. To reach as many positive Covid-19 cases as possible the Test and Trace Corps has deployed a subset of case investigators that are solely responsible for conducting database research and directly reaching

out to doctor's offices to track down cases and contacts for whom we initially do not have a phone number. The Test and Trace Corps is also working with a wide range of community based organizations across all boroughs to broaden its outreach to contact who may have been unresponsive to phone calls through our hit accept campaign. In addition the Test and Trace Corps operates the Take Care Initiative, the city's program to help all New Yorkers safely separate to prevent the spread of the virus. Our Take Care program provides free hotel rooms with wrap around services for New Yorkers who are unable to safely separate in their homes and supports those who are safely, who are separated at home with dedicated resource navigators. Through partnerships of 11 community based organizations across the city the Test and Trace Corps employs resource navigators that help New Yorkers overcome logistical issues they may encounter while safely separated in their homes such as access to basic services like food, medicine, and laundry. To date we have 220 resource navigators on the ground helping and it helps 16,735 New Yorkers quarantine safely whether it be in their home or through hotel support. New Yorkers with Covid-19 are

also connected to a comprehensive range of support services such as grocery delivery to help them isolate at home. To help all New Yorkers safely separate at home and monitor their health status the Test and Trace Corps contact tracers check in with families via daily calls, text messages, and conduct in person visits as necessary. These calls and texts allow us to gauge the progress of Covid-19 cases and contact, ensure proper compliance with preparation protocol, and connect individuals to more supportive services as necessary. Thus far we've been able to reach 90 percent of all Covid cases across New York City continuing to meet and mostly now surpassing our program goal that we've set up since mid June, after we launched on June 1st. For New Yorkers isolating outside of their home at our isolation hotel they receive transportation to and from the hotels, meals, wellness checks, support services, home health coordination and home care for up to 14 days. Since the launch of Test and Trace Corps 1,350 New Yorkers have been served through our hotel program. At the hotel meals, clean clothes, and medication refills for anyone who is isolated in quarantine is provided for those who require. Using telemedicine Health and

Hospitals also performed remote medical checks on those in isolation and quarantine and evaluate the individuals to determine whether they should receive care at a hospital or not. In August the Take Care program began shipping Take Care packages to New Yorkers who test positive for Covid-19 and contact with confirmed positive cases. Take Care packages include a medical grade mask, sanitation wipes, hand sanitizer, a pulse oximeter, and a thermometer. To date we have shipped 8,744 packages to New Yorkers. Earlier this month the Test and Trace Corps also launched the city's first brick and mortar location within a house of worship. The city is now partnering with the Episcopal Church of Saint Alban the martyr to expand Covid-19 testing sites in Queens while serving communities of color hardest hit by the pandemic. We know that Covid-19 has, had a disproportionate impact on communities of color with black and Latino New Yorkers dying around twice the rate of white counterparts when adjusted for age. Since the launch of Test and Trace Corps over 450 field based contact tracers have been deployed to communities across the city with a particular emphasis on those hardest hit by Covid-19. To engage

check in, and gather contacts of confirmed Covid positive cases. Community engagement specialists also spend time in communities speaking with those contacts who might have been exposed to the virus. Tracers we call case investigators support their efforts working remotely in focusing their time on conducting calls to New Yorkers with a positive Covid-19 result. Together that with the New York City Department of Health and Mental Hygiene, DOHMH, we have developed and implemented nimble hyperlocal responses to swiftly engage with communities hardest hit by Covid-19. So far hyperlocal efforts have been rolled out in Tremont, Bronx, Sunset Park, Brooklyn, Soundview, Bronx, Borough Park, Bensonhurst, Brooklyn, and Ozone Park in Southeast Queens. Through this the city is providing 10 million dollars in grants to community based organizations ranging from 50,000 dollars to 750,000 dollars in these areas to encourage communities they serve to get tested and engage with contact tracing. In these communities on site resource navigators are stationed at rapid testing sites across the community to immediately connect people with services including hotel rooms if needed. The city is also providing 7.8 million

dollars for community based organizations to promote public awareness around Covid-19 and Test and Trace Corps services. These 39 community based organizations serve low income and vulnerable communities across the five boroughs with increased risk of contracting Covid-19. Additionally to ensure the Test and Trace Corps can meet the diversity of New Yorkers from all backgrounds 40 distinct languages are spoken by tracers in our program today. We have surpassed our hiring goals meeting our milestone prior to the completion of our first month. The Test and Trace Corps has recruited, trained, and hired over 3600 contact tracers with the advisements and expertise from 40 Department of Health experienced contact tracers. Together we manage and ensure the high quality of effective remote and field based contact tracer teams. There’ve also been many operational achievements since quickly coming up to speed the service that is our response to the Covid-19 pandemic. New York City Health and Hospitals has been able to successfully conduct 450,000 Covid-19 tests since mid-April and currently operating with the capacity to test approximately 60,000 people per day in New York City with plans to expand that

capacity further in the next few weeks. Currently we are, currently we are testing between 20 and 40,000 people per day citywide. Our contact tracing efforts have been impressive. We're proud to say that those we have engaged 96 percent of cases and 93 percent of contacts report to us every day not having left their home. These percentages are significant when it comes to ensuring that New Yorkers are doing all they can to curb local transmission. The Test and Trace Corps is now reaching 90 percent of all Covid cases citywide everyday surpassing our initial benchmark goals. Nearly five months since the program's launch Covid-19 visits to the emergency department, case numbers, hospitalizations, deaths, and test positivity has been at their lowest since the epidemic began. All of our progress is going to be monitored and tracked by all New Yorkers for free and in real time through our Test and Trace Corps dashboard. The dashboard is readily available on our website and is updated weekly. In doing this we are able to help all New Yorkers feel safer in their city and demonstrate that our efforts are actually working together with them. The Test and Trace Corps is committed to ensuring that every New Yorker can

access free and confidential testing, receive the care they need and safely isolate to combat any further transmission. Through our robust and citywide partnerships we'll continue working with the city council to educate and help New Yorkers to fight Covid-19. Besides getting tested we want to remind all New Yorkers to follow the core four; stay at home if you're sick, wear a mask, social distance, and keep your hands clean. Again, thank you for your time this morning and the opportunity to speak on this program. I look forward to answering any questions you might have.

SR. POLICY ANALYST EMILY: Thank you Dr. Long. I will now turn it over to Chair Rivera for questions.

CHAIRPERSON RIVERA: Thank you so much. I also want to just acknowledge we've been joined by Council Member Ampry-Samuel. So I guess let's start with thank you for your testimony. I appreciate what you've gone over. I guess we want to get into some of the details. I know you've informed us of cases, tracking and monitoring contacts who were exposed in managing all of those cases and that contact data. Hit Accept, the Take Care Program, the 90 percent

contact rate, it all sounds very good. But can you discuss how you measure success? What data are you using to show that the program is working. I know you mentioned the dashboard but later on in the hearing we're, we're, we're going to at least ask you on the record for more disaggregated data, get into super, super fine detail. But can you discuss how you measure success and what data do you use to show that the program is actually working?

DOCTOR LONG: Mm-hmm, yes, that's a great question. I appreciate you asking that. I'll note that the metrics I'm about to share with you, we put these out publicly because they're the right thing to do. Before we hit them and actually before we were on some cases even close to hitting them, this is months ago now, so we know from models that have been done, evidence based, and the consensus of experts that there are a few key things you must do to keep the virus suppressed, drive down virus levels across the city. Number one is you have to be reaching enough people. Number two, and we set the bar 90 percent there, number two in models show this percentage specifically is that you need to be, 75 percent of your new cases, completing interviews with them get,

getting them to isolate. And then number three is you need to, for contact, also, be getting them to quarantine, you need to be interviewing and completing interviews of 75 percent of them as well and getting them to quarantine. Let me walk you through a couple of data points about where we are right now. With respect to people that we're reaching when we started the program we were not, we didn't even have phone numbers for 90 percent of people. But now through evolving our program, knocking on people's doors we're consistently reaching more than 90 percent of all new cases. There's no qualifying that denominator, everybody that gets diagnosed with Corona virus across New York City, that's what matters. Number two, in terms of, of new cases we're now completing interviews consistently with more than 75 percent of them which is the benchmark we set out before we were, before we certainly hit the metric. But since then we've really had a laser focus on that and I'm proud that we have worked really hard and have hit that metric. And then of those cases too I mentioned the important thing is getting them to isolate so that they don't go out there and infect up to 2.5 other New Yorkers each. 96 and now 97 percent

of all of our new cases are confirming with us day by day that they are isolating. So the metric is real, they are isolating. And then the third metric is one where Chairwoman Rivera was still working on it. So for contact we need to be completing interviews with 75 percent of them. Right now we're, at 60 percent. That is an area where we need to do more work. And we have several strategies that we're implementing now as we're happy to go into more detail for, but we need to get to 75 percent to that. And again one of the metrics we set out before we hit it and we haven't hit it yet. That's a key area of focus for us.

CHAIRPERSON RIVERA: Okay, and so in terms of you know you mentioned that in your testimony we know the Latino and black New Yorkers are, are dying at twice the rate of their white counterparts. So I want to ask about in all of this work in terms of equity we know that we need to have people that look like the community, that have trusted relationships, talking to Latino and black New Yorkers. So do hiring practices reflect this reality. And specifically I want to ask about language services. I know you mentioned there are about 40 languages spoken by the

tracers, but I want to be very very specific in terms of do your hiring practices reflect the reality of that two to one number? And, and again specifically I want to ask about Haitian and Carribian communities, many of them in Brooklyn and across the city feel like there is not enough outreach done to those particular groups so can you speak to that as well?

DOCTOR LONG: Yes, absolutely. So I'm going to start and then I'm going to turn to our Chief Equity Officer Annabel Palma to share her thoughts as well. So, three parts to your question. First is do our tracers represent our communities. Second is languages. And third is in particular the Haitian community and have we, what's been our strategy for engaging with them. So the first part of your question around do our tracers represent our communities. If I had to tell you what our secret ingredient is for how we have achieved, hit our benchmarks, I really truly believe it is because we have hired the right people. We hired New Yorkers to help New Yorkers. Well over half of all our tracers are not only, almost all of them are from New York City. But well over half of them are from our hardest hit communities meaning they lived through the

horrors they all lived through in March and April and their communities. So when they're knocking on the door of somebody in their community nobody get it, nobody knows what that person went through better than they do. And they went through the same thing in March and April. Even this morning I was on the phone with one of our tracers. I make a point of talking to our tracers as much as I can to get a sense of what they're, how we can make improvements to the program. And this gentleman happened to be from borough park so we talked about what's going on there a little bit. He shared with me, said you know Dr. Long I have to tell you, we would not be effective at all if we didn't actually represent the communities we came from. Nobody understands borough park like I do or like people that are there from their due. Nobody outside of borough park could really get through to that community. And I think he's probably right. And I think that, that the, our ability to really get through to people and engage them with the program and then they actually isolate and quarantine speaks to our success there and our tracers being the right people. I won't belabor that point further. Your second question was around languages. So our tracers

speak more than 40 languages and in particular our tracers that make our monitoring phone calls, I think well over a third, I think it's close to 40 percent now, are bilingual. And then I'll give you an example of why this matters to me. So in some of our communities, and you alluded to this a little bit Chairwoman Rivera in your, your comments earlier, we've seen ethnics. And in particular these are communities that we know have, had a very hard time through Covid back in March and April as well. Look at Sunset Park, look at Soundview. We saw upticks in both of those communities. So what we did, and I'll give the example of Soundview here because I actually visited the site myself and saw it happening, is when you have a rapid test, if it comes back positive you have a team there of tracers in person that speak the seven languages of that community that will do immediate instantaneous contact tracing with you. So instead of talking about our completion rate being 75 percent or whatever it's 100 percent there, it was 100 percent because they, they get you right there and they speak your language. I practice primary care not far from that community and I know the languages spoken there by that community and I think that was a

very, your point is very well taken. The way that we were successful there is because we had people that spoke the language of the community were from the community. I couldn't agree with you more.

CHAIRPERSON RIVERA: Well I just want to, just want to ask about that, I know that the language is going to be critical I mean you can go to Elmhurst hospital any day and there might be 100 languages spoken there alone.

DOCTOR LONG: Yeah.

CHAIRPERSON RIVERA: So had I, I totally understand… I just wanted to ask about you know serving some of the communities that were the hardest hit. And I know that we were going to hear from Ms. Palma in a second. But let me just ask you about, because I know that my colleagues have questions as well. And that also Chair Levine will be asking a bunch of questions. What is the current distribution of tests dispensed and contract tracers per number of residents in each zip code in New York City. Assuming you have the language that is serving those neighborhoods if you could just answer that. A current distribution of tests dispensed and contact tracers per number of residents in each zip code in

New York City and doesn't reflect the granular case positivity rates in each zip code.

DOCTOR LONG: Mm-hmm, great question. So let me just repeat it back to you to make sure that we can look up the data right in front of us now. Then I'm going to turn to Annabel to give my team a second to pull this together because we have it. So the first part is round testing. We, we have data on as we've opened sites where we've opened them and how that's been guided by race, ethnicity, and community needs. So we're going to pull that for you in a moment. And I'm going to look to Jackie Bray to share that if she has it and if not if Doctor Wallach does. And then the second part of your question was around contact tracers. I said to you that well over half of our contact tracers were from our hardest hit communities which represent obviously a portion of the New York City population. So they're disproportionately represented there. I can tell, I can say that to you for certain but if we have the percentage we can pull together right now we will, otherwise we can get back to you by the end of the day with that. But Annabel can I turn to you both to weigh in on all of these issues, in particular I want

to be specific about the Haitian creole communities that Chairwoman Rivera was talking about as well.

ANNABEL PALMA: Sure. Thank you Dr. Long. Good morning Chair Rivera and members of the Council. As Doctor Long had mentioned we are dedicated to making sure that we are serving the community and you know the languages that they are mostly comfortable in speaking. We, you mentioned we had gone to Soundview. We've also have gotten, have gone to Sunset Park. We have dedicated, ensuring the materials are translated in the languages that are most effective for the message to reach particular communities. I know that when we were doing our hyperlocal focus on Soundview one of the languages that was missing was that Haitian Creole on language and we put, we were able to put, turn around materials and get folks on board to help us communicate with that, with that particular population. And we've been focusing on strengthening our partnerships with our CEOs who aren't in these communities and know, and have you know their pull on, on the community that, and, and what the community needs are. We have been invited and continue to be invited to speak to communities via

WebEx, zoom meetings, or on, through the local community boards. And we always made sure that we're again doing it in, in specific languages. I know that I, to date, have done over 30 WebEx in, in Spanish getting the information out to both individuals and answering the questions again in, in their appropriate languages. And we will continue to do that as we, our program, our program alone. But again, right it's crucial the punishments that we build with those community based organizations to allow us to continue to do the work that needs to be done and, and to continue to flag for us with what else we need to be doing to ensure that communities are not feeling like they're being left out.

CHAIRPERSON RIVERA: Are you working with, with MOIA, with the Mayor's Office of Immigrant Affairs? Specifically the Offices of Language Services Coordinator for those communities who may not be represented well by tracers. So for example, the languages with less than five speakers. Are you working with, with that agency?

ANNABEL PALMA: Absolutely. We do a lot of, we do a lot of community meetings on, together along with MOIA. MOIA flags for us many of the

meetings that we have, that, that our team has attended since the start of the Test and Trace Corps. And so we, we work closely with them to ensure that we are hitting all those communities.

CHAIRPERSON RIVERA: And when will disaggregated date by language, zip code, etcetera, be available for contact tracers? I guess I also want to ask that can Test and Trace and DOHMH disclose racially and ethically this disaggregated data on contact tracing and Covid mortality and morbidity to the public?

ANNABEL PALMA: I know that Dr. Long can answer that more specifically in terms of when we are able to share that, that data. That data is being worked on and, and we, you know we can pull it together and definitely share it with the council once we pull it together.

CHAIRPERSON RIVERA: Okay and can you also include subgroups to be disaggregated in the same way and publicly available? For example by age, whether the person lives in public housing, language use, the language that you used and the language that was needed. I think that's all going to be really really important in terms of transparency from the public.

So we can build that trust considering the history of, of how certain communities have been underserved when it comes to, to help care and medical services. So I, I want to make sure that I, I actually want to turn it over to Chair Levine. I want to make sure he gets a chance to ask questions and that we have quite a few council members who I think want to drill down on, on some of this data that we've requested that's currently not available. Chair Levine.

DOCTOR LONG: Yeah. Well Chairwoman Rivera can we take, would you mind if we took one second to answer your data question for the [cross-talk]

CHAIRPERSON RIVERA: …said you had to get it to me later.

DOCTOR LONG: I appreciate it.

CHAIRPERSON RIVERA: …better answer…

DOCTOR LONG: I'll tell you what. We have part of it now and then I may get to you the second part later. But I'm going to turn to Jackie to share what we have now. Jackie.

JACKIE BRAY: Ah there we go, now I can. Sorry, I put it on mute. I just wanted to say in terms of tracers and how we allocate their resources throughout the day. They're allocated based on cases.

Right? So the more cases a community has the more tracers that will be deployed into that community. So that's how we do that. In terms of the data that you're requesting, we already, I just want to make sure everyone knows where to find in the data that's already being released. Right? So we already relieved data on the zip code of where our tracers are from. So you can see that on our website once a week every week. We already released data on the race and ethnicity data that is available through tracing. It is absolutely true that people can decline to answer those questions. And so it's not a complete data set and it doesn't represent every single person's case. But it is as complete as we have. We're not keeping any of that data. You have all of the data we have on that. I, also, in terms of morbidity and mortality want to point you to the Health Department's website. DOHMH has been posting mortality statistics since I think the end of March at least. And the, that is disaggregated by race and ethnicity and so that's not that type of data, mortality data or fatality data is not the type of data that the Test and Trace Corps would maintain or would track. That's really the type of data that you'd want to go to the Health

Department's website for. I think the data that we're going to get back to you on is how many tests, how many tests are collected specifically by the resources that the city is using by neighborhood or by zip code. The data of how many people are tested by neighborhood has been public from, from the get go. And that is really available on the Department of Health's website. So I just want to be clear that a lot of the data is already out there and, and happy to think about how we can get you different data or better data or drill down or cross tab but a lot of the data has already been.

CHAIRPERSON RIVERA: Would just say, I think it's released by race, I don't, I don't believe it's race and zip code. But I can go back and check and, and we don't know how many positive cases by zip code and race. That's what we mean by disaggregate. So we're looking really for that really broken down as well as incorporating some of the other factors I mentioned. And then clearly you're working very closely with DOHMH. So having that kind of compiled together instead of having to pull from different websites to me makes a lot more sense to have something comprehensively. But I'm going to go ahead

and, I just want to thank you for answering that question. I'm looking forward to kind of the outstanding data that you mentioned. And again just to turn it over to Chair Levine.

CO-CHAIRPERSON LEVINE: Well thank you so much Chair Rivera for that excellent line of questioning and just want to follow-up on one important point you raised. And Dr. Long great to see you and the team. Dr. Long could you just remind us how many total contact tracers you currently have working?

DOCTOR LONG: A bit north of 3600.

CO-CHAIRPERSON LEVINE: And how many of them are Yiddish speakers?

DOCTOR LONG: Yiddish speakers, I'll have to double check the data. It's a handful right now so we're progressively hiring more.

CO-CHAIRPERSON LEVINE: Your website says, has an asterisk next to the number of Yiddish speakers which I understand means between zero and five, is that correct?

DOCTOR LONG: Yes.

CO-CHAIRPERSON LEVINE: Can you not, can you not tell us where, where in that range of zero to five?

DOCTOR LONG: We don't, the reason we don't go between zero and five is it could be potentially identifying. So this is, we use that asterisk for a variety of categories, not just for language. But what I can, when we surpass five we'd be happy to share that with your right away.

CO-CHAIRPERSON LEVINE: Well the, the fact that we're even parsing whether it's one, two, or three out of a workforce of 3600 considering the current preponderance of cases in effective communities in Brooklyn is, is really a problem. It, it reflects a failure to adapt to the cultural needs, the linguistic needs of this community. We, we have got to higher up amongst people who have relationships and trust in the communities that are now experiencing the surge. And Yiddish speaking ability is just one obvious way we need to do it. So, so please report back to us on your progress on that.

DOCTOR LONG: Absolutely.

CO-CHAIRPERSON LEVINE: You talked about a testing capacity which is greatly expanding which is

really a good move, it's up to 60,000. Yet, in recent days we're testing only about 30,000 or so people a day. This, so why, why the discrepancy between our capacity and the amount of testing performed?

DOCTOR LONG: Yeah, that's a great question. So we've all, our mantra has always been that we want every New Yorker to be able to get a fast, close, convenient, and free tests wherever you live. That's why we work very hard to build up our capacity to give everybody that opportunity. What we're doing now to drive up our testing numbers which is important because testing is the first step of the contact tracing is focusing on where we see, especially these upticks, and really leveraging a lot of the capacity that you're referring to there to bring people in to be tested. That's something that we're working very very hard on now. We're converging 11 of our mobile units. For example, the majority of our fleet in the zip codes where we're seeing the uptick now and we're doing a variety of other things to drive up the testing levels in those communities in particular. But our capacity allows us to be flexible and to move where we need to be.

CO-CHAIRPERSON LEVINE: Just continuing disparity in the rates of testing between communities particularly whiter and wealthier neighborhoods which are testing at higher rates than low income communities and black and brown communities throughout the city. You actually, you actually list these numbers by zip code on your website over the past month and it shows that in a place like Brooklyn Heights 12, 12,000 tests per 100,000 residents done over the past month. In a place like West Harlem, in my district it's 7,000 per 100,000 residents over the past month. How do you explain that disparity and what are you doing to close that gap?

DOCTOR LONG: Yeah, it's a great question. So we, within Test and Trace Corps, within the Health and Hospitals' umbrella control a certain portion of the actual testing site. Other sites like CityMD existed before we came about. So what we are doing is when we build new sites, whether it's a, where we send our mobile sites or our new brick and mortar sites, we will get into everything you just said in terms of guiding us where we need to go. Additional factors we take into place is, our, we have a very expert and active community advisory board. And we

ask them, if we need to go in this community this is where the data is guiding us, where should we go, which corner should we go to. And actually in Sunset Park a good example of that is there was a need to your point of doing more testing in that community for sure. And we've asked our community advisory board, we actually set up one of our mobile units on the exact, literal, like one foot of pavement that they said is the best place to speak. So what we're doing to be very concrete is we're putting all of our resources in terms of where we deploy them to, to fill the gaps that you just I think articulated very nicely.

CO-CHAIRPERSON LEVINE: This has been a persistent problem throughout this whole pandemic. People with resources have just had easier access to tests. And it's, it's profound inequality at its worst and we have to do more to close that gap. Particularly for the black and brown communities who have endured such a terrible blow throughout this crisis. I want to ask about antigen testing which does offer the exciting prospects of quicker and potentially cheaper testing which we so very much need for the next phase. But it appears there's a

problem in that the systems for reporting results from antigen, antigen testing are not rock solid, that some providers who have their own machines aren't reporting into the state system. What, can you estimate what percent of antigen test results are getting reported in?

DOCTOR LONG: Yeah, that's a great question. So just to back up and then I'm going to turn to Doctor Daskalakis to go into more detail here. To be clear, any test, any point of care or rapid test be it a lateraquil [sp?] IntOGen or be it a point of care like the Aben [sp?] IV now which is one of the machines that we use which is on antigen test, any of those tests need to be reported in. And that's how we do contact tracing. So there's a requirement that they need to be reported in. And I will turn to Doctor Daskalakis to share more about how that works and if we have any thoughts about how big the problem we're trying to solve is.

DOCTOR DASKALAKIS: Thank you Doctor Long and thank you Council, Councilman Levine. So we have actually provided a significant amount of technical guidance to providers with a recent health alert to make sure that they were aware how to report antigen

tests in the state ECLRS system. So as a provider to a few patients as well I can tell you that ECLRS is something new to people. It's not something that we, that providers generally use. So we're really deeply diving into technical assistance as well as working with the state to make sure that their assistance and their messaging to providers is adequate in terms of how to report these point of care tasks. One of our problems is that we only know about tests that are reported, not about tests that aren't reported. So I can't give you a percentage or an idea of a constellation of how many folks are not submitting these test results. But we are definitely seeing antigen tests coming in which I think means that you have made, the message is getting through. Obviously always more work to do in provider education and outreach and we'll continue to do so.

CO-CHAIRPERSON LEVINE: Thank you Doctor Daskalakis. Doctor Long you talked, you gave us significant detail about contact tracing results and we appreciate that. One point, I just want to clarify, one percent of people that you interview are giving at least one contact?

DOCTOR LONG: Yeah, so let me pull that up here. I believe the answer is 71 percent. My team can confirm that in a moment. One of the things that we've done to fully answer your question though is we also ask people if the reason they're not giving us a contact is they don't want to or if they genuinely don't have any contacts. Because you know in theory, in a perfect system people should have no contacts. So part of the, we've added those questions to understand what the real problem there is. I'm going to turn to Jackie in a moment but I believe the specific is that 13 percent of people when we ask don't give us contact. And it's neither because they don't, they, they say they don't have one or, nor because they've given us one. It, it's because they don't want to or they don't feel like they, they don't feel encouraged to. But Jackie did I get those numbers right and do you want to share more.

JACKIE BRAY: Hi, yeah so 70, 71 percent is right. 71 percent of folks who we talk to do provide a contact, at least one contact. And then of the 29 percent who don't, 55 percent of that group report having no contact. So it really is truly a small amount of people, yeah 14 percent, 13 14

percent of folks who both report, verbally report no contact but also tell us have a close contact but they're not willing to report to us.

CO-CHAIRPERSON LEVINE: Okay obviously we want to, we want every single person who test positive to share their contacts. We know that requires a leap of trust and that's why we just have to continue to be out there making the case and building those relationships.

JACKIE BRAY: Absolutely.

CO-CHAIRPERSON LEVINE: Thank you. I wonder if you could share with us, kind of a big question, where is spread occurring to the extent you're able to track it, is it occurring at home, amongst households? Is it occurring in public settings like mass transits? Is it occurring in illicit events like house parties? We've seen those kinds of reporting out of other cities around the world and even some in the US. Tell us the picture here in New York.

DOCTOR LONG: Yeah, that's a great question. I'm going to start and then I'm going to turn to both Doctors Daskalakis and Doctor Vora and Jackie to share more about what our, where our data

is exactly leading us now. So big picture, we see where cases are coming in from, so for example there. One of the reasons why we've had a focus on travelers that have spent time in other states that have high levels of Covid now is we know one in every five new cases has been from somebody that's travelled to another one of the states. In terms of where transmission is happening here we can give you the example of what we saw at Sunset Park where the percent of people testing positive was up to 4.2 percent. We did exhaustive analysis looking at is it community transmission, are there any focal sites. And what we're seeing a lot of is again community transmission, a transmission among family members. I'm going to turn now to go into more detail. Let's start with Doctor Vora.

DOCTOR VORA: Thank you. So transmission like Doctor Long was saying is occurring in a variety of different settings as we can imagine. And this is an imperfect science right, because we, we have to make some assumptions about where someone might have gone that's infected. And we, in many instances we'll never know for sure. But like Doctor Long was saying a large proportion is happening within households

because that's the most common sorts of contact that a person will have. Some of these new cases do report that in fact that they were in contact with someone who was sick and that, that establishes that transmission more clearly. Other examples of where transmission might be occurring are among essential workers because these are people who are going out to the work, sometimes they do not have the luxury of being able to work from home given the nature of their jobs so we have seen transmissions under those circumstances. Some proportions is happening in people who are going to gatherings and events whether indoor or outdoor. And again the, it's very hard to, to determine for sure that transmissions definitely happen from this person to the next person because given the nature of how widespread Covid is even in a lower setting of transmission like we are in New York City right now. It still takes some, some conjecture based on the information that we have.

CO-CHAIRPERSON LEVINE: It'll be really helpful for the public to get an accounting of that because it will inform people's decisions and I think it will help us understand the impact of reopening steps, etcetera.

DOCTOR VORA: Yeah.

CO-CHAIRPERSON LEVINE: Today we have another milestone with indoor dining service being permitted at 25 percent. This may be a question for Doctor Long. Are you tracing in cases in which a server tests positive or a patron tests positive in that setting?

DOCTOR LONG: Great question. I'm going to broaden it a little bit if I may because I know where you're going with this and then I'm going to turn to Doctor Daskalakis. So we look at facilities in how we identify and detect clusters in a couple of sophisticated ways. Indoor dining is one of many examples of the type of settings we look at with information we get either from contact tracing or from things like our sat scan which is an underlying analytic program that does geospatial evaluation for new cases over time. Demetre you want to share specific to indoor dining but generally how we look at facilities.

DOCTOR DASKALAKIS: Great. No, yeah this is a perfect way to give an example around facilities in general and I think it will also demonstrate what the flow of data is between test and trace and DOHMH

to really create what is in fact a assembly line of contact tracing and the, like that. So when an individual is identified to have a association with the facility such as a restaurant, so let's say that an individual diagnosed with Covid, they're interviewed by Test and Trace. They say I work at a restaurant or I was at a restaurant. This then goes to our facility team that interacts very closely with the Test and Trace team. The facilities team then does an investigation and will notify the restaurant. Part of that will be to see sort of what level of engagement is necessary. Do we need a list of folks who are at the restaurant? If it's an employee when was that person working, what were that person's close contacts. So in fact just like all of our facilities when identified as a facility exposure we do the same, we will do the same for restaurants as we do for others.

CO-CHAIRPERSON LEVINE: Including of course schools. And maybe you could say a word about the protocols there because it's very much on our minds this week.

DOCTOR LONG: Yeah, thank you for asking about that. So schools build off of everything that

Doctor Daskalakis was talking about and I have a few other enhancements on top. I'm going to start and then see if Jackie Bray wants to add anything on here about our situation room. So in schools we have a situation room that brings together, to use Demetre's word, the assembly line approach is how data flows, and how we really all do work together across the city. We go there today, we're all literally in the same situation room with defined responsibilities as its, flow of things, so that we know if there's a positive case in a school that student or a teacher, that pod will go in quarantine for two weeks. That's the golden rule that will happen 100 percent of the time. We'll additionally do contact tracing on top of that to see if there are any other close contacts for that student or teacher. Then if there's another case that happens in a school that's where the situation room gets activated further and DOHMH does an investigation to essentially determine if there's transmission potentially going on in the school. If there is that will be a reason for us to have them schools switch to remote learning for two weeks. Or if there's not and it's pretty clear where each of those respective cases track the Corona virus then we

can reopen schools safely. But in either case the, the pods are going to be quarantined for two weeks regardless. Jackie anything you want to add there? And then we're happy to go into more detail for you Councilmember Levine.

JACKIE BRAY: I just want to say you know the situation room is really working I think quite well. The, we, we're collocated T2, DOHMH, DOE. We, and we're sort of being hosted by the Department of Buildings and very grateful for their support. We've identified 202 cases amongst DOE students or personnel of which 105 needed an intervention. 105 of the 202 were physically in the building at some point during their infectious period and so they needed a classroom closure or building closure. We've been able to execute all of those rapidly and tracing begins in the room. In the room we have teams calling through close contact, talking to cases, and making sure that that data gets appropriately over to our larger team and our larger system. So happy to take more granular questions but we are, we are very very focused on keeping on robust testing and tracing on the schools and keeping the school safe.

CO-CHAIRPERSON LEVINE: Thank you. We're anxious to pass it off to our colleagues so one final question. Very brief. I think this is the ultimate measure of the successful contact tracing. How many of the newly identified cases that test positive are known to you as contacts?

DOCTOR LONG: So I'll start and then we're, we can get you a more comprehensive answer, analytic, what using, the analytics that we're doing if not now potentially little, a little bit later today for, on that too. So around almost a quarter of our new cases were contact that developed symptoms that became cases. And that's one of the big reasons why you do this. In that case if those, those contacts were already in our program where we were talking to them when they were developing symptoms so we're able to get them to intervene to get them to isolate immediately and that makes a substantial difference. So your point is very well taken there. We're combining that number together with the other cases that otherwise were known to our program aside from being symptomatic contact. I'll turn to Doctor Vora and Jackie if they want to share more there. And otherwise we're happy to circle back with something

more comprehensive on that but I just want to give you flavor.

DOCTOR VORA: Yeah, like Doctor Long is saying for, for contact tracing we're trying to establish chains of transmission. And as many of the cases that newly occur that are among known contact is, is a good sign right? And so it's very important that we are monitoring contact and then when they become symptomatic we start managing them as cases. This is what Doctor Long was referring to. We also have had a number of popup tent sites around the city that have been placed strategically in parts of the city where we are seeing perhaps an uptick in percent positivity. And in those popup tent sites where there's rapid testing, under the same roof we've actually also stationed our contact tracers. So right then and there in real time we can begin accelerated contact tracing. So we identify a case in person with the clinician and our contact tracer is right there to continue the conversation and identify contact of that case. And we are in neighborhoods. These are hyperlocal responses. And our contact tracer in that same moment then reaches out to those contacts and encourages them to come by and get tested because

they're all often in the same neighborhood. And we had very good success with getting those contacts identified on the very same day coming around to get tested with rapid testing. So these are some of the strategies we're using to encourage testing of contacts which is really important.

CO-CHAIRPERSON LEVINE: Thank you Doctor Vora and thanks to everyone from the administration. Appreciate your answers and I'm going to pass it back to you Madam Chair. Thank you.

DOCTOR VORA: Thank you.

CHAIRPERSON RIVERA: I will now ask the moderator to call on my colleagues for questions for the administration.

SR. POLICY ANALYST EMILY: Thank you Chair Rivera. We're first going to turn it over to Council Member Eugene. Council Member Eugene do you have questions that you would like to ask? Council Member Eugene you are not currently unmuted. I will give you, oh there you go.

COUNCIL MEMBER EUGENE: Can you hear me now?

SR. POLICY ANALYST EMILY: Yes, thank you. You may-

COUNCIL MEMBER EUGENE: I want to thank one more time, the Chair, the two chairs for the wonderful job in their leadership on this very important issue. And I want to thank also all the panelists. I gots a few question but I'm going to- write down. We know that every time that we do testing for any type of disease, any time there's testing there are always false, false positive and false negative. You may think that it's positive, it's not positive and negative because of manipulation because of any condition. So my question is, what isn't relates for a when, you know the people who are entering the testing. When they have a patient who is tested negative, especially negative, is there any other follow-up, a clinical follow-up or x-ray or what, x-ray, or any other thing to ensure that with many the- [technical glitch]

SR. POLICY ANALYST EMILY: Councilmember Eugene I think you're breaking up a little bit.

[technical glitch]

SR. POLICY ANALYST EMILY: Councilman.

CHAIRPERSON RIVERA: I'm not the only one, right. Okay.

SR. POLICY ANALYST EMILY: No, there is some technical difficulties. I think we might have to mute Councilmember Eugene and come back to him. So we can turn it over to other councilmembers. So thank you again. So as a reminder if a councilmember would like to ask a question and they have not already done so they can use the Zoom raise hand function. Councilmembers will, will need to keep their questions to five minutes. The Sergeant at Arms will-

[silence]

COUNCIL MEMBER BARRON: Thank you very much, and to the chairs for holding this-

[silence]

COUNCIL MEMBER BARRON: -sure that you know that district 11239 which is basically Starrett City has been cited as the number one zip code in terms of deaths where they use the ratio in the for mortality. You're talking about hyperlocal, hyperlocal, hyperlocal. Tell me what you are doing in zip code 11239 specifically that relates to preparation for this.

DOCTOR LONG: So, I'll start. And I appreciate that question. I'm going to back up for a moment just to, we use the word hyperlocal a lot but

I'd like to just explain what it means because then I, potentially ask for your partnership. So hyperlocal is where we identify that relative to other parts of New York City there are a variety of different issues going on whether it's a higher number of proportional cases, whether it's a higher proportion of people testing positive, or whether it's less people getting tested in general, or a combination thereof. In Sunset Park to give the example there, when we went to Sunset Park, what we found that 4.2 percent of residents there were testing positive and they didn't have enough testing to begin with. So what we did is we brought in our mobile units, our rapid testing machines, created a lot of community based partnerships which I think was the secret ingredient there and we were able to drive down the percent of people testing positive by more than two-thirds. We then went to Soundview because we were seeing issues as you're describing there as well, same identical result. We drove down the percentage of people testing positive in Soundview which is near where I practice primary care by two-thirds. In your community the secret ingredient would be the same. If we're seeing signals if that's where

we need to apply more testing for example- [cross-talk]

COUNCIL MEMBER BARRON: Wouldn't the signal be the data of what we already know has occurred? Wouldn't that be a signal? I mean you're talking about going out and trying to find where there might be additional cases when in fact we know where an extreme number of deaths proportionally have occurred. So it seems to me once again what we know is systemic racism and its tentacles are not, are not being overlooked so that we're not looking at where black or brown people have died in exorbitant numbers and saying listen, Council Member Barron this is in your district, do you have any plans, have you made any efforts, what can we do to assist you. Or Councilmember Barron this is where we are putting up a mobile unit and these are the groups in your community that you can expect to bring services. I haven't been reached and contacted in that before, in that regard. I do want to say that Land Use did reach out to me with data about what was going on in this zip code. And Land Use is now going to set up a meeting with the manager of Starvette City to see what particularly effective measures we can put in

place now. But I don't hear that from you so- more time I'd like to hear that.

DOCTOR LONG: Councilmember Barron I'll take-

COUNCIL MEMBER BARRON: Yes.

DOCTOR LONG: We are coming in, on October 7th with a new site for your community and might ask of you, my long winded ask, forgive me, I sometimes get long winded, was going to be can you work with us to-

COUNCIL MEMBER BARRON: Certainly.

DOCTOR LONG: And then what we would need from you is, again I think what we did in Soundview and Sunset Park was we brought the testing but then we worked with the community and I think that was the way to do it. We're going to bring the testing to you and if you work with us I'm confident we can have the same result we did in Sunset Park and Soundview.

COUNCIL MEMBER BARRON: Thank you. And I have a couple of seconds left. When you talk about testing do you recommend that people have multiple tests spaced over a period of time or just one test done whenever and move on?

DOCTOR LONG: Good question. So it depends a little bit on the risk factors you have. So if you're a person that has a job that involves multiple interactions with other people, of course we should always wear masks and social distance, but it's reasonable to get yourself checked say every month. If you're in a position where you're only at home, you never leave home you have less of a reason to get yourself tested at that frequency per say. What we do then is depending on the type of job you have-

[cross-talk]

SERGEANT: Time-

[cross-talk]

DOCTOR LONG: Healthcare workers we test every month in our system but we have other criteria that we use as well for other types of workers but I think our time's expired but follow-up with me offline. I'm happy to share more.

COUNCIL MEMBER BARRON: Thank you very much. Thank you to the chairs and I look forward to your call or your email. Today would be fine. Thank you.

DOCTOR LONG: Got it.

SR. POLICY ANALYST EMILY: Thank you Councilmember Barron.

COUNCIL MEMBER BARRON: Thank you.

SR. POLICY ANALYST EMILY: I see that we're joined again by Council Member Eugene. Would you like to pick up your line of questions?

COUNCIL MEMBER EUGENE: Yes, yes thank you so much. I'm sorry about, we had a technical difficulties. My question is about the testing, the testing. We know that Covid-19 is a very complex situation. Before we believed that it was only respiratory, respiratory disease but this is not the case right now. Could been any system in the body. But when somebody is tested, is tested negative is there any other follow-up procedure to ensure that we have a good result? Because we all know that in any test there's false positive, false negative. What do you have in place to ensure that the person who is tested positive or negative, especially negative, so we can ensure that the result is correct?

DOCTOR LONG: Yes, that's a great question. Actually Councilmember Barron who I think may have stepped away started to answer it for you so I will, goes off of what she said. For negative test

results, a negative result today does not mean that two days from now you won't have symptoms and potentially be contagious. So negative results give you a point in time but it is important that when you, one negative result, it doesn't mean that you're going to not have Covid for the rest of time. We do think that it is important that you get tested frequently. For example, in our system in Health and Hospitals, more than 40,000 people our recommendation is for our employees to get tested once a month. That is because if you're negative this day this month it's not to say that you're going to be negative this day next month. So it's important to have a reasonable frequency. We don't believe that there is a whole lot of false positives, meaning a positive is actually not positive. What we do see though is a positive result doesn't necessarily mean you're contagious. If I tested you today and you were positive, I tested you again in three weeks, you have no symptoms, you're positive again you probably have residual virus in your nose. It doesn't mean you're still contagious though. So that's how we break down the false positive and false negative sort of if you will. Yeah situation.

COUNCIL MEMBER EUGENE: Thank you for everyone. What I'm talking about, I'm not talking about someone who tested negative is truly negative or truly positive, I'm talking about false result because of manipulation, because of any type of a reason. Because we know there's not 100 percent test in the world. That doesn't exist. It's also some possibility of mistake of error. It could be human error. It could be manufacture error. It could be anything. And then it doesn't mean, tested positive or negative or this is not the correct result. Let's say for example, especially negative. I'm worried about, I'm concerned about those people who are falsely negative because we know this is a very contagious disease. Let's say we test a somebody, somebody is tested negative and we say oh, that's okay it's negative. But that person has the possibility to infect many other people. So my question is after one test if the person is tested negative, when you say one month, one month is a long time. A lot of thing can happen, you know a lot of contamination can, can occur. So is there any protocol when you test somebody and especially that person has all the symptom, other clinical

manifestation, because before we did, we did believe that Covid was the cause of a respiratory disease. That was the, the believe before. But right now it could be anywhere. The person can have, can come with it now, come with any other symptom and then, then the person may have the Covid, may have the virus but the Covid test say that oh this person is negative. So what do we have in place to minimize the mistake, to ensure that the result that we have is accurate.

DOCTOR LONG: Right I- [cross-talk]

COUNCIL MEMBER EUGENE: And again I got to mention also that we cannot, we cannot have 100 percent accuracy in anything.

DOCTOR LONG: Yeah.

COUNCIL MEMBER EUGENE: I'm talking about what do we have to minimize the mistake, to increase, or to accuracy of results.

DOCTOR LONG: Yeah, so I understand your question. No test or medicine as you know doctor is 100 percent. So if you're a contact and you're symptomatic we treat you as a case even if you have a negative result because the degree of your exposure is too much and no test is 100 percent. So we treat you as a positive in that case regardless of a

negative result. If you have a positive result then we know you 100 percent have it. I'm going to turn to Doctor Wallach to share more. But I understand your question. We do look at the extent of exposure and risk as helping us to judge the result itself. Andrew.

DOCTOR WALLACH: Great thank you. Thank you. And thank you for the question. You're absolutely right. As Doctor Long Said no test is 100 percent accurate. However our testing overall for Covid-19 is pretty good. I think the issue is when we talk about our rapid testing you get a negative test result on a rapid test that's considered a preliminary negative. And we actually do confirm that negative test result with the test that goes to our lab. So in that case you are correct. It is a preliminary negative that we confer. Now regardless of all that we still recommend that everybody has universal masking, that people continue to social distance and that people continue to use good hand hygiene. Because as Doctor Long pointed out even though you may test negative and it is a true negative today you can still develop Covid several days later. So that is why the importance of

universal masking and social distancing is so important throughout the pandemic in New York City to prevent further spread. And the other point just to reemphasize that Doctor Long had mentioned that even if you test negative and you have signs and symptoms that are consistent with Covid-19 you are treated as if you have Covid-19 for the reasons that you mentioned, that no test is 100 percent perfect. And we have to treat the individual and their clinical signs and symptoms at that time.

COUNCIL MEMBER EUGENE: Thank you very much Doc. But my last question is that since you have been tracing and testing and tracing for a long time do you have in record the number of false positive or negative? Do also observe in this situation or any false positive or negative? And do you have any record?

DOCTOR LONG: Yeah, so I'll start and I'll turn to Doctor Wallach. It's important to say that in, to answer your question the test characteristics go to the FDA for any given test. So what we do is we look at those test characteristics and then we also make sure that we monitoring our system as we using to test as well because every test has to validated

before we use it. So Andrew do you want to share more about, our sort of process for looking at tests.

DOCTOR WALLACH: Yes. Yes, great. Thank you Doctor Long. So that's exactly right. So any test that we use in New York City is first approved by the FDA in order to- authorization act to make sure that the- have. On top of that New York City Health and Hospitals also then does a separate validation study of those tests before we employ them on large scale verification of population. So I don't have an exact number Councilman to give you as far as the actual number of false negatives and positives although I can tell you it's definitely on the low end. And to that point you get, as part of our clinical guidance for any patient- we emphasize very strongly that should they develop signs and symptoms we would ask that they isolate at home and return for a repeat testing.

COUNCIL MEMBER EUGENE: Thank you very much Doctors. And thank you to my Chairs. Thank you very much.

DOCTOR LONG: Thank you.

COUNCIL MEMBER EUGENE: Thank you.

SR. POLICY ANALYST EMILY: Thank you Councilmember Eugene. I'm now going to turn it over to Councilmember Ampry-Samuel for questions.

SERGEANT: Time starts now.

COUNCIL MEMBER AMPRY-SAMUEL: Good morning everyone. I have the same line of questions as Councilmember Inez Barron. And so I just want to publicly cosign on all of her questions. In particular I wanted to kind of dive into like lessons learned from this spring and the summer. Knowing that what we are hearing is predicted for the fall and winter. And so I just wanted to you know just kind of get a sense of what did you- for now but she is, she covered that. So I just wanted to kind of get some clarity on the website. And that's because you know a lot of people do not open that particular website and this is also you know for the public as well. So there was mention about the zip codes of the contact tracers and just as an example when I pull up 11212 there are 54 monitors and tracers listed under that zip code. So can you give me a sense of what does that mean. Because when you go to the definitions, the reporting definitions under monitors and tracers it says counts of case contact monitors and case

investigators, community engagement specialists hired or contracted and the languages they speak. So can you kind of just give me a sense of what does that mean? The number 54 next to the zip code 11212 and what do they actually do. And also with that same line of questioning, on the same datasheet it speaks to 1,273 languages spoken by the tracers and that's amazing. But in my district we do speak different languages. But in that zip code 11212 the language that is spoke is Brownsville speak, like literally. And so that's a, a local dialect right? And it may sound like English but when you have a conversation with someone in my district you may not be able to communicate with them because of the different type of communication. And that's real. And I've said this before. I remember having the conversation around you know how people, or the lack of trust that people have for government, the lack of trust that people have for elected officials period, healthcare professionals. We don't go to the hospital. We don't have primary care physicians. And so if somebody who speaks you know anything on this list, somebody who you know clearly is, you know, has an ethnic background calls someone and asks about their, you

know, activities you may not get a positive response. And so can you speak a little to again that number of contact tracers in certain zip codes? And how do you make sure that the people that are working in certain communities should be there? And just as an example when I walk around the community, even during census 2020, and there are enumerators out there they may speak different languages but when they knock on that door and try to you know communicate with someone in my district it doesn't work because they can't encourage them or influence them to, you know like to respond. So can you just speak to that a little bit?

DOCTOR LONG: Yeah, yeah. Those are great questions. So the first part of your question was around 11212, the number 54. So to be concrete on that, those are the, that's the number of our overall contact tracers that live in that, in that zip code. So now actually it gets to your second point which is, it's one thing to define languages but it's another to understand how to engage people in a community even if it's under the same umbrella, the same language. And you know that's why we, we were so intentional about making sure that we hired contact tracers from all of our, especially our hardest hit

communities because you know that number right there just shows the number of people that we have on our team that are from your community. And I would hope they would understand your community better than anybody else would. But if there are other people, other community groups. The contact tracers being from the community is one way that we seek, we want to engage with you in your community, but also working with CBOs, so if there are any CBOs that we could or should work with we'd welcome continuing that conversation as well.

COUNCIL MEMBER AMPRY-SAMUEL: Okay, just a couple more seconds Chair because I exceeded my time-

SERGEANT: Time expired.

COUNCIL MEMBER AMPRY-SAMUEL: So I travelled and I had to quarantine when I returned. And I had someone call me. And the person that called me was reading from a script. I was annoyed by the questions. I was annoyed by, and I'm a very helpful person like in the end I continued, like I, I explained to her like you know thank you for doing this, you know you may want to do X-Y-Z. It was a, it, it was not a pleasant call. And I'm, I'm me right. And so I can only imagine the difficulty she's

had with other people. And so I'm very concerned about, and you know this is my zip code right, and so I would hope that somebody that would call me was from my community right? Because that's what you're telling me right? What, like I personally explained leaving, having you know a contact tracer contact me, and being in contact with me for damn near every fricken single day. I'm like you don't have to call me, don't call me please. But it, it was a person that was not from my community. And it was-

DOCTOR LONG: You're correct in that. So the person, if you were god forbid diagnosed with Coronavirus the person knocking on your door would be the person we'd want to be from your community. For travelers, what you're referring to is we're actually just calling travelers to let them know about what the quarantine is and let them know about resources we can offer. So that, that's different than trying to build trust through the contact tracing program. The call you got was for education, information, and offering resources. But if, so if you do, and I hope you don't, or if you have a loved one that gets diagnosed with Corona virus that's where we think

it's especially important. Because that's what we're asking you for contact.

COUNCIL MEMBER AMPRY-SAMUEL: But I, I have a question, I'm sorry let me just.

DOCTOR LONG: Yeah.

COUNCIL MEMBER AMPRY-SAMUEL: I would question that because if I travel, I came back, I did not take a Covid test, right? And I could have been you know visiting with other people. I could have been outside. I could have put others in danger and there would be a need for the contact tracer to be able to communicate with me to find out what, you know what was, what were my activities when I returned. So we shouldn't just be like a quick call type, like I would, I would want the same person that's calling to be just as invested in making sure that you know like I'm not just am I being safe but, and responsible but you know the other people who have connected with or contact, been in contact with. So I just wanted to-

DOCTOR LONG: Helpful feedback. Yeah I mean I, it's a, if you do get tested and your test results come back that puts you into the group of people where we, where we've gotten it right in terms

of having people from our communities be the ones calling. But I think your point's well taken. We'll take that back. I appreciate your feedback. It's good to, I appreciate your experience. Thank you.

COUNCIL MEMBER AMPRY-SAMUEL: Thank you Chair. I had other questions but-

CHAIRPERSON RIVERA: Alright and I just want to add Councilmember Ampry-Samuels point is that if you can just commit to getting machine readable format and fully disaggregated data made available to all of us so we can read it and we can assist our communities. Clearly we all want to be involved.

DOCTOR LONG: Yeah.

CHAIRPERSON RIVERA: I mean I have been very proactive in getting testing sites and as soon as we get them I'm very excited about them, you kind of just you know pop up in the location that we worked on together but I don't really get notice. So it's even little things like that. Anyway I want to make sure that we move on to the, to the next councilmember who has a question. Is Councilmember Reynoso with us?

[background speaking]

SERGEANT: Time starts now.

CHAIRPERSON RIVERA: You're on mute Antonio. Councilmember Reynoso.

COUNCIL MEMBER REYNOSO: -because of where we are-

SR. POLICY ANALYST EMILY: It seems like we may be having some technical difficulties with Council Member Reynoso. Were there any other councilmembers who have questions who have not yet asked them? If you do, please use the raise hand function. I see that Councilmember Ayala has now raised her hand.

SERGEANT: Time starts now.

SR. POLICY ANALYST EMILY: Okay.

AYALA: Thank you. -take forever, just got your hand up. But my question is I, I mean I'm from- and, and my office is actually open. It's been open for some time and we've been you know documenting information on individuals that come in contact with the office so that we have them in the event that somebody gets ill and we can kind of practice right, what, what you're discussing today. However I'm a little bit, not disappointed but just, I haven't heard anything from the, from the city. And I think that, like I'm very active in my community and I know

a lot of my colleagues are. We're out there doing bookbag giveaways, food distribution drives. I mean you name it, we're doing it. And so we, come in contact with a large percentage of our constituency and it would be nice to have access to some of this data in real time. I mean I haven't heard from anyone in the administration about contact tracing happening in my district. And I have parts of my district zip codes that had the highest numbers in the entire city, Highbridge in the South Bronx, zip code 10029 here in East Harlem were the hardest hit. And I really haven't heard from anyone. No one has requested a meeting or called me or said listen this is how, you know this is what we're doing in your district, this is how you can be helpful and partner with us. And I think that that is, that's important. That's an important part of the conversation because we are your community validators right? We are the people that you know the community trusts to come to them with valuable and reliable information. So I'm not sure why, if it's purposeful or what, why that is that there is no communication between your offices and the elected officials.

DOCTOR LONG: Yeah, well actually I'd love to take you up on your offer there. So you have, you know your community better than anybody does and I have an ask of you. What we need to do, especially now, to keep New York City safe is we need to do as much testing as we can. But even if, and this is to an earlier point, I think this was Councilmember Levine, we've done a good job of building up a lot of capacity. But now we want to bring everybody in to use the capacity that we have built. Now we're targeting it where we know it's needed most so we have capacity across the board in every community. So what I love to do is have Annabel Palma on the phone now, can we connect our offices together and talk about how to get the word out and how we can help and maybe you can help get the word out about bringing people in to get tested and we'll do the testing?

ANNABEL PALMA: Absolutely I will. This, this new thing. Thank you Doctor Long. I absolutely will follow up with Councilmember Ayala and get this boat rolling in terms of you know- the turn going out to her community and bringing the resources that we need there.

DOCTOR LONG: That would be great. Thank you.

SR. POLICY ANALYST EMILY: Thank you Councilmember Ayala. We're joined again by Councilmember Reynoso.

SERGEANT: Time starts now.

COUNCIL MEMBER REYNOSO: Thank you. Thank you all for your patience. I was off on a call for a couple of seconds there. I have two, two concerns that I want to address. The first one is if we have less than five Yiddish speakers and the most recent increase in Covid testing or positive cases come in largely Yiddish communities how is it that let's say five, I'm going to just say five of them, best case scenario, five Yiddish speaking contact tracers were able to connect with 90, what you'd call a 90 percent contact rate when we have hundreds, hundreds of positive testing or positive, positive cases in let's say just South Brooklyn alone in my part of the district South, south of Broadway in Williamsburg. How, the math there doesn't add up unless those five contact tracers are talking, are calling people like every five minutes they're meeting someone new.

[child screams]

COUNCIL MEMBER REYNOSO: Sorry that's my son in the background.

DOCTOR LONG: That's okay.

COUNCIL MEMBER REYNOSO: So I can't under, so I don't understand how that math works there. And then I'm going to ask a second one which is.

DOCTOR LONG: Sure.

COUNCIL MEMBER REYNOSO: Black and brown communities that are adjacent to the, or zip codes that are adjacent to zip codes that are currently have many positive cases. Like my district is 11211. So south of Broadway and north of Broadway. There's a lot of cases off Broadway. There's less cases north of Broadway. But now that north Broadway is starting to get, it's going to, it's starting to have cases as well. So the uptick is happening there. The death rate is twice as much as black and brown communities. I really need to understand on 11211 what is happening to ensure that the, that the positive cases don't continue to turn up where in the Latino part of the community which has a higher death rate if exposed to Corona virus. I just want to understand those two things.

DOCTOR LONG: Yeah those are two great questions. I'll answer both of them specifically. First one, your son in the background, [laughs], the dancing. My son's 18 months old, I understand. To answer your first question, honestly we can't do this alone. In the communities where we're seeing an uptick now we, with our tracers and our teams, we need to work with the communities if we're going to succeed. That's how we succeed as a city. We need to work with community based organizations. We need to work with local leaders. That's what we, what we are doing now. We're working with as many community based organizations, all of which speak Yiddish, that we possibly can. And we have 300 plus people handing out masks. And we have, we've gone to 300 synagogues to hand out masks too. We don't just hand them out, knock on, anybody who were there, we work with the community to talk about why this is important and to talk to community leaders why this is important too. And with you and with other community leaders we need to work together if we're going to succeed here. In particular with communities like the ones where we're seeing an uptick now. To get to your second question I'll go back to you. What do we do about other

communities that are bordering on where we've started to see the uptick. Very good question. The answer is simple. We need to do testing. We need to work with you to do as much testing as humanly possible. And you tell me where you need us, we will be there. Once we do that we'll not only have a better sense of what's going on in your community but even more important than that we'll know how we need to intervene. We'll know what the cases are we can intervene now immediately. So if we work together we can do it.

COUNCIL MEMBER REYNOSO: Thank you. Sorry I was, I was muted. I hear you about working together but Broadway is the boarder of my district right? So my relationships are north of Broadway, not south of Broadway. So I don't know who you should be talking to south of Broadway but I know that if you don't do the work south of Broadway that it's going to affect north of Broadway. Because council districts tend to be like small little cities within themselves I get, I get myself in a position where I can't help my people because of the lack of relationships I have with other districts. So I'm going, and look you can walk down south of Broadway and more than 60-70

percent of the people there are not wearing masks. It is like very clear. So you know there has to be responsibility by government, not by me by as an elected representative but by Health and Hospitals and by DOHMH to do this work to make sure that that doesn't happen specifically because my district has a higher opportunity to, has higher death rates than the community that's south of us. So I just- have a very, understand that dynamic because it's important. And still you're saying a lot of communities, so what you're saying is if you have a community organization to do the contact tracing for you or making the calls for you, it's a volume thing. I don't understand how you can get through the volume if you only have five Yiddish speakers.

DOCTOR LONG: Yeah we're working with-

SERGEANT: Time expired.

DOCTOR LONG: If I can stand Sir I think it's an important question. South of Broadway to your point is where we're working with CBOs, organizations, and community leaders to get the word out with starts at testing. You can't do any contact tracing if you don't get tested. And then on the contact tracing part, right now, we're actually, our

numbers in terms of people that we do contact tracing with, we actually are seeing a similar proportion of new cases in the communities that we're talking about here that are isolating meaning not leaving their homes when we diagnose them with Coronavirus as compared to the rest of the city. The challenge we're having is getting people to come out and get tested. And then having them pick up the phone when we call. But I totally agree with you, that's where, that's where we need help from community leaders and community based organizations. Once we get you on the phone we know what we're doing but we need help in getting the word out. For you, north of Broadway, it starts with testing. So I'm not asking you to-

COUNCIL MEMBER REYNOSO: Okay.

DOCTOR LONG: -south of Broadway problems but I am asking you is tell us where we need to be north of Broadway and we'll be there.

COUNCIL MEMBER REYNOSO: Alright so I will be doing that and I'll be talking to Commissioner Jackie Bray I guess who's been helping us out. I know she was on a call with us. I just want to say, just acknowledge that once we saw the upticks the commissioner reached out to us right away. We were

supposed to be on a conference call. I didn't make it but other folks did. So I'll be following up with her again to see what we can do. But I really appreciate the, everyone here. Thank you.

DOCTOR LONG: Jackie Bray is very good. Thank you.

SR. POLICY ANALYST EMILY: Thank you Councilmember Reynoso. We'll now turn it back over to Chair Rivera who has additional questions.

CHAIRPERSON RIVERA: A couple more questions. I wanted to ask for a full list of all community based organizations and community leaders working with the T2 program. If you could send that over to us I would greatly appreciate it. And speaking of your coordination you know with community based organizations, with community leaders, hopefully with more elected officials who really want to be engaged in this process. How have you coordinated with state agencies on contact tracing? State agencies, federal agencies I guess making sure that we're all working together. And are you sharing contact tracing information with the state contact tracing program ComCare.

DOCTOR LONG: Good question. I'll start and then I'm going to turn to Jackie Bray who we were just talking about. Just as way of background here, anybody that gets a test in New York City whether it's CityMD or whether I said my clinic at Morrisania in the Bronx in Health and Hospitals, all positive test results go to the state, the State Department of Health, because it's a reportable disease. Same as many others. It's not unique in that way. Then the positive, their results come to our local Department of Health and that's where the data stays under strong protection as with any reports received. What's unique about Corona virus is to your point the extent to which we need to work together with the state to have alignments in terms of our respective approaches. So with that I'll turn to Jackie to talk about our coordination with the state.

JACKIE BRAY: Hi, yeah so we, anytime that we see a case or a contact that we find that lives out of jurisdiction whether that's Nassau County or Westchester or New Jersey or Florida our team, the team that Niel Vora leads has an out of jurisdiction team and they're sending that information via a system called Effiac [sp?] to that jurisdiction.

We're also receiving out of jurisdiction information from everyone as well and entering that into our system. The state uses ComCare in a similar way that we use salesforce. So other counties, instead of their contact tracers using Salesforce as their sort of customer relations management software they're using ComCare. Salesforce and Comcare are not, they're not like talking to each other every day. But we are absolutely passing the information about cases and contact back and forth between jurisdictions. New York state counties and also other states. Niel anything else on that one?

DOCTOR VORA: Yeah, I think you got it correctly. And also on the part about the federal collaboration we're not sharing information with federal government except when someone has travelled on an airplane. And the federal government would then notify that there was a person who was on a plane who might have exposed some New York City residents and then we can follow-up with those New York City residents and so in that way we are collaborating with the CDC. Okay how are you, how is H&H utilizing Department of Health expertise to implement the T2 program. I know that there, the Department of Health

there's some time constraints so I wanted to make sure that we got a chance to ask you, how is the department of, how directly involved in the program. What are, what role are you playing in regards to community engagement and education.

DOCTOR LONG: Yeah.

CHAIRPERSON RIVERA: So how, how are you all working together. And I'd love to hear from, from the commissioner as well, to hear from Demetre.

DOCTOR LONG: Well me, I'll start and then I'll pass it to Demetre. I want to note, that Doctor Vora is actually from the Department of Health as well. So half the people on our team, on the screen here that I see are from DOHMH and half are from Health and Hospitals. And actually that's a pretty good description of how we send everything the whole way through. Everything we've done in terms of program design and implementation has been in lockstep together. We do contact tracing for all cases. The Department of Health does cluster evaluations, investigations, uses our data to inform where we should focus our efforts. Even on the community engagement side we have staff that work together to go for example evaluating schools. They

even, they passed out masks, spoke to community based organizations which is how we're passing out 300,000 masks right now in the affected areas. So Demetre can I turn to you to share more about our, our work together.

DOCTOR DASKALAKIS: Certainly. Thanks for the question Chair Rivera. So I think we, I sort of used the assembly line analogy before and it really, it really is that. So I think that different strings for different parts of this program which I think it can broadly is T2 including the DOHMH part of T2 where we really are capitalizing on the back that T2 is able to do really high volume calling and really get to people in a way to get the information that we need. And then using the expertise at the Department of Health with more sensitive, often more complex investigations specifically around clusters really allow them to have an interactive process where we identify individuals who are in those facilities who are potentially contacts. We then ship through that same assembly line the contacts back to T2. And because of the way that they're staffed they're able to do all of the follow-ups. So I think we have a really great flow of data and information.

Additionally we are, as how often do we meet it's really hard to say because we are in one constant 24 hour meeting but we, in terms of our communication. So I think that as we hear, as we hear about, is really anything that we need to talk about we have really direct lines and our division of labor is not siloed but rather again on this, on this continuous spectrum of experience. So I think you know really just like the rest of this response that pulls from many many agencies and sort of this one big citywide response. This is a great example I think of how to integrate different talent pools and different staffing models to create a better delivery system of an important educational and public health program.

CHAIRPERSON RIVERA: Thank you for that. I just wanted to ask one more question about the testing. Can you tell us how soon communities are, are getting results. I asked I guess more specifically the turnaround time, do turnaround times differ per community. And I just want to, and then I'm going to ask about rapid tests after that.

DOCTOR LONG: I'll start and then I may go back to Doctor Daskalakis to share more here. So with turnaround times, the median for New York City now I

believe is two days. And that cuts across all of New York City. And then within our Health and Hospitals sites we do have an ability through both how we set up our lab, our arrangements but also how we are able, how we prioritize based on where we're seeing upticks to do even better than that. So as many of our, so we also have our new, a New York City public helpline where we're able to run tests within 24 hours. So we have a lot of abilities, a lot of ability to in communities where there is need, actually turnaround testing as fast or faster than pretty much anybody else across the country. Demetre do you want to share more about the distribution across the different areas of New York City or anything else you want to add?

DOCTOR DASKALAKIS: No I think, I think you got it. And just confirming that, that citywide turnaround time is two days. I also want to note that as you remember, sort of as, as testing was scaling up you know there were sort of extremes, like some people were waiting for 14, so those extremes have really dropped too. So you know even the top 25 percentile of people getting test results are getting them really fairly tightly around two days. So really

the various things including the launch of the, of the, the pandemic response or PRL lab has really been helpful in, in doing this. So, and also again the Covid express sites and, health clinics at the Department of Health really with fast turnaround times I think overall the city is going in a great direction. And again it looks like we have more capacity. So it's all great news from the turnaround time perspective. Yep.

CHAIRPERSON RIVERA: Thank you so much. I think one of the concerns I receive from the community advisory board were just making sure that you know certain communities didn't get the turnaround time quicker than others as was noted in kind of the historic disparity throughout the process. And I just want to know what is rapid testing going to, when do you see it being available to the city? Are there current efforts to ensure that those who need the test get priority on the basis of risk factors as opposed to anyone who wants a test? And I guess that goes for TCR and rapid tests.

DOCTOR LONG: Yeah, that's a great question. So right now we have tens of rapid testing machines and they are move, they are mobile. So what

we're doing now is moving all of them into where we need them the most which are the communities where we're seeing the uptick right now. So that's been part of our hyperlocal response the whole way through is we've brought in rapid testing machines because we know that's where we need to really bolster testing in those communities like Sunset Park or Soundview or Ozone Park. Right now we're focusing our rapid testing machines in on again the zip codes that have more than three percent of people testing positive. And they're actually going live tens of them today. So, and we're going to bring in, we're bringing all of our troops to focus in on these communities and so more to come there but today's the day to go live.

CHAIRPERSON RIVERA: Okay thank you for that. I just think you know transparency is just so key and so I know I've actually a little bit about data privacy but it, it is a very very big concern. I know you have some things on your website posted that says we're committed to protecting your health information, maintaining confidentiality and privacy. But on the what is tracing subpage it says; will my contact tracer share my information with law enforcement or immigration services. Any information

you share with your contact tracer will not be shared with immigration, law enforcement, or justice officials unless required by law. And so again just to the data point as to this information, keeping it secure and your coordination with agencies to make sure that we're protecting that very very sensitive information. So I just want to turn it over to Chair Levine and make sure that he gets you know last crack at, before we let you all go. And thank you so much for your time this far.

DOCTOR LONG: Thank you.

CO-CHAIRPERSON LEVINE: Thank you Chair Rivera. And I'll forgo questions because we have members of the public who want to testify. And of course want to let the administration get back to work during this time of crisis. I do just want to make the point that you're hearing a lot of urgency from, from us, from our colleagues right now because we understand that there's a distinct possibility that the second wave is coming, in fact it may already be starting. And you know we've had thankfully three plus months where the spread of the virus here has been fairly limited. And so that's given us a chance to build out these symptoms for

testing and tracing but now those symptoms are about to be under much greater stress as the number of cases rises and as contact tracing becomes much more complicated because- Excuse me, I'm just going to pause and ask my wonderful family to quite- working at home folks- So what we're anticipating a more challenging stage ahead and it's why we're putting these tough questions on the table. And we're pretty certain that what lies ahead will again disproportionately impact marginalized communities in this city. And so we have to redouble our efforts to reach out to them, to have, speaking the languages that they speak to build trust in those communities. That's really the only way we can tackle the inequality of this pandemic. And so we just want to urge you to continue to push on that front so that we do reach the people we need to in the challenging months ahead. That's it for me. Thanks again to the administration.

DOCTOR LONG: Thank you.

SR. POLICY ANALYST EMILY: Great, seeing no more questions from councilmembers we will now conclude the first panel and move on to the public testimony. Thank you again members of the

administration. The public testimony will be limited to three minutes. After I call your name please wait a brief moment for the Sergeant at Arms to announce that you may begin before starting your testimony. Councilmembers who have questions can use the Zoom raise hand function and you'll be called on after the panel has completed its testimony in the order with which you're, you have raised your hand. The first public panel in order of speaking will be now, Doctor Chunying Hua, Allie Bohm, and Hollie Yee. Doctors, Doctor Hua you may begin.

SERGEANT: Time starts now.

DOCTOR HUA: Hi, good morning, or rather good afternoon. Thank you Chairpersons Rivera and Levine for holding this hearing. It couldn't be more timely. My name is Niox Chunying Hua [sic]. I'm here representing the New York Doctors Coalition which is a collection of physicians and healthcare advocacy groups located in or with local chapters in the New York area bringing together over 20 member groups with over 20,000 doctors and trainees. My talk will be in three sections touching on, because it's been an equity and contact tracing on New York City Department of Health and Mental Hygiene's initial

role in pandemic prevention and current preparedness as well as inequality and isolation options and treatment access which I, you know, potentially more relevant for future hearings, but I think it's important- the issue up front. So, to begin, in March our group proposed in city limits the class of the pandemic hot zones based on the regional disparity in case rates and death rates at the time. So New York City as we've discussed zip codes with transmission rates near or above three percent deserve priority for SARS-CoV-2 or rapid testing and contact tracing resources. This is because the three percent level has been proposed by various institutions including Harvard Global Health Institute as a positivity rate consistent with appropriate access to testing. However, until there is widespread vaccination former hot zones are also more likely to experience disproportionate suffering and death just due to the social determinate of health that led to this disparity and remained risk factors for harm from Covid-19. So hot zones described by the March definition are zip codes with death rates of 500 or higher per 100,000 population or with case rates of 3500 or higher per 100,000. So these include East New

York, Canarsie, Flatland, Rockaway, and Coney Island in Brooklynn, Northeast Bronx, Pelham, Morrisania, Kingsbridge and Fordham in the Bronx, and West Plains, Elmhurst, Flushing, and Jackson Heights in Queens. And so these districts continue to require intensive test, trace, and take care resources to mitigate the health inequities highlighted during the first surge. Therefore we recommend focusing on T2 or T3 reverses on the original hot zone zip codes in addition to those with test positivity rates currently at or above three percent. We maintain that areas hit hardest in March and April remain at highest risk due to chronic disadvantage, racism, and clinic underinvestment. So next let me turn to let me discuss the New York City DOHMH's role in the past and current pandemic response. So in March the New York City Department of Health and Mental Hygiene was involved.

SERGEANT: Time expired.

DOCTOR HUA: Okay. In setting up alternate care sites- these have been underutilized. And currently, let me just summarize very quickly since my time has expired. Currently what we have repeatedly heard is that after health and hospital

took over contact tracing they lacked statutory authority to collect information on health, public health information since only the DOHMH has a statutory authority to collect this data, a memorandum of understanding- jurisdiction including over 100 staff members. However H and, Health and Hospitals is still running into problems related to lack of jurisdiction including delays in the time of collection of Covid-19 surveillance data from hospitals and private practitioners around the city. So it's, deserves I think asking why DOHMH was not maintained as a Director, in a directing position in the contact tracing process with Health and Hospitals to assist us. Because if it’s a greater hiring capacity and manpower instead of closing it to potential conflict of interest through hiring of optum. And lastly I just want to bring our attention to the inequality in isolation options and treatment access, around the city as we know now that outcomes across city hospitals were highly unequal during the initial surge. According to data from April only around 26 percent of Covid-19 patients were hospitalized and many of the elderly and frail and people of color among the outer boroughs did not

obtain equal access to treatment and timely admission compared to those in Manhattan. Also we note that these alternate care sites including USNS Comfort and Javits Center were underutilized and in particular egress from overwhelmed hospitals in the outer boroughs was impeded to these alternate care sites because of the hyper select of 49 item criteria that initially excluded patients with Covid-19. So there's also another huge problem with hospitalizing only 26 percent of patients in the midst of a pandemic and not- to the individual lives at stake. It's basically just from the outset that hospitals do not have a role to play in interrupting the virus' chain of transmission. And you know because a negative test result was not necessary for discharge in New York many patients returned to the communities to endanger others and their loved ones around them. So these are mistakes that I think we can learn from as we approach a probable and imminent second surge. First with a clearer sense of the biological and social determinants of morbidity and mortality. Screening criteria for recommending mission and follow up could be more targeted at those who can benefit the most while the specific terms of the mission criteria I

think require thorough review of the literatures. It should ultimately result in lowering the threshold for admitting patients in comparison to the relatively high threshold in March and April on taking into account particularly racism as a risk factor. Second, existing hospital facilities, especially clinically underfunded understaffed safety net hospitals require disproportionately more support. The needs of existing community care facilities including overflow area should take priority over ultimate care sites which if they are to be utilized maybe better suited at sites for isolation under monitoring for asymptomatic or minimally symptomatic cases. It stands to reason that a moratorium on the closure of existing and patient acute care facilities such as Kingsbook Jewish Medical Center in East Flatbush would be- imperative. Thank you. My time has ran out.

CHAIRPERSON RIVERA: Thank you so much. I just want to make sure we can get to all our panelists, make sure you can hear us, and we appreciated, I think we, we're very clear in back in May how disappointed we were at the change with Department of Health and Health and Hospitals. So

thank you. Just want to make sure everyone can see the clock and can hear us for when we prompt you to wrap up. I appreciate everyone for waiting this long. I really really, next panelists.

SR. POLICY ANALYST EMILY: Thank you. Thank you for your testimony. So we're now going to move on to Allie Bohm.

SERGEANT: Time starts now.

ALLIE BOHM: On behalf of the NYCLU thank you for holding this hearing. We all share the perfect desire to safely open our city and there is broad consensus that contact tracing is essential to doing so. Unfortunately a necessary ingredient for effective contact tracing community trust is still missing. According to the data H&H released yesterday only 48 percent of cases share their contacts with contact tracers. Although this is a slight improvement from the summer it is still woefully inadequate. And thanks to a toxic cocktail of socioeconomic factors, physical environment, and inferior access to healthcare black and brown communities are disproportionately likely to suffer from Covid-19. These are all, these communities are also disproportionately likely to be alienated from

our healthcare system as a result of the racial biases that pervade that system and they also bear the brunt of both the police in generally and specifically to enforce the Covid-19 related social distancing. As our nation stands in the midst of a long overdue reckoning on racism and white supremacy any distrust black and brown New Yorkers might have feels understandable. But New York City has the tools of its disposal to build the necessary trust in our contact tracing program if only we would use them. In July H&H put out a request for proposals for community based organizations to deliver the city's Covid-19- It did not provide a mechanism for the community based organizations to help define the government's plans to community identified needs base a missed opportunity. Just as community members have been more effective at convincing their neighbors to wear masks and adhere to social distancing community members and organizations are more likely than outsiders to know how to convince their neighbors to identify their contacts to get tested to self quarantined when necessary. They are also more likely to be attuned to community specific needs around stigma and safety whether regarding sensitive

associations, immigration enforcement or overcriminalization. H&H should use this opportunity to learn from the community based organizations it solicits. Second, effective contact tracing requires individuals to share a constellation of intimate information with contact tracers; their location, their health status, and their associations. H&H cannot guarantee that contact tracing information will be shielded from law enforcement and immigration authorities. If individuals have any reason to believe that sharing the details of their lives will expose them or their loved one to criminalization or deportation they will not participate. Fortunately, there is a bill on the governor's desk right now, A10,500C/S8450C that would ensure that law enforcement and immigration enforcement cannot serve as contact tracers or access contact tracing information and that an individual's contact tracing information and that an individual's contact tracing information cannot be used against them. City councilmembers should do everything in their power to urge Governor Cuomo to sign that that bill immediately. Contact tracing is too important to get wrong. Ensuring that the T2 program is culturally and

linguistically competent and that contact tracing information collected to stop a public health emergency is shielded from law enforcement and ICE are not just privacy and civil rights, they're public health imperatives. Thank you for the opportunity to testify today.

SR. POLICY ANALYST EMILY: Thank you for your testimony. We're now going to turn to Hallie Yee.

SERGEANT: Time starts now.

HALLIE BOHM: Hi, my name is Holly Yee and I'm a policy coordinator at the Coalition for Asian American Children and Families. Thank you Chairs Levine and Rivera and members of Committee on health and on hospitals for giving us this opportunity to testify on behalf of our 70 plus member and partner organization and the highly immigrant APA communities they serve who have been left behind in the city's Covid response and must be centered in the depression of revitalization as they face greater challenges and loss due to the pandemic. While the city has touted the advancements that have been made in testing capacity recently there's still inadequate testing in low income neighborhoods which have been hit

especially hard by the Corona. We've heard from community members and organizations that severe shortages of testing resources are made in their neighborhoods with results taking anywhere from two days to two weeks to be reported back to them. We've also heard unfortunate testimony from our communities that testing centers and resources have been pulled out or heavily reduced in some of the most hardest hit areas such as Elmhurst and Corona both heavily APA community populations. Ensuring best practices around Covid-19 testing is key to New York City's recovery. It's critical in making it safe for our children to learn in person and for our community's revitalization efforts. Furthermore for our city to continue phases of reopening we have to think about more than three percent citywide average transition rates special that the city is focused on currently. We're asking city council today to hold our public health systems accountable to our community's needs. First we demand that the city provide accurate data collection, disaggregation of data on infection rates, hospitalizations, and deaths in the APA community in order to best respond to this pandemic and reopen safely we must at least be able to track

race and ethnicity and languages spoken to those who are tested so we can appropriately trace and take care of them. We're not doing this adequately now and our communities and our struggles of being a race. Second, we demand that schools and partnerships with the city's help, can ensure that critical information gets to the families in languages they need. It's only recently H&H was able to translate help- outreach- the city's top 11 languages required by local law yet this was too late and still not enough. We have to be prepared to reach and support students and families who are limited English proficient. And third we demand that the city address the mental health needs of children and families especially those who are- preventing who have been targeted during this pandemic. There needs to be a system in place that can be prepared to help our community- isolation discrimination, xenophobia, and more as they return to daily life. Our communities are consistently overlooked in the distribution of resources which is harmful to us as well as other communities of colors who are denied the same resources due to the perceived success of our community. The 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. As always CACF will continue to be available as a resource and partner to address these concerns and we look forward to working with the city to better address the inequities that we see day in and day out within our communities. Thank you.

SR. POLICY ANALYST EMILY: Thank you for your testimony. I'm now going to turn it over to chairs for questions for the first panel.

CHAIRPERSON RIVERA: Chair Levine I'll turn it over to you if you have any questions.

CO-CHAIRPERSON LEVINE: Thank you. This is an important panel, all three of you brought up so many critical points. Allie just a question for you. Do you have an assessment on the data processing system that we're using for contact tracing and the extent to which you feel it meets adequate standards on privacy and data security.

ALLIE BOHM: I wish I could answer to that Chairman. I think unfortunately like much of the program many of the data systems have been shrouded

in secrecy. So we don't have a ton of information but I will touch base with our technologist and get back to you to see if we have any more specifics. We've also put forward some public records requests to the city trying to ascertain more information about their data practices.

CO-CHAIRPERSON LEVINE: Thank you. Yes I, I know that you, you are fighting to build confidence in the program so that people participate. It is really critical that we push hard on these questions of privacy, data security, and a rock solid guarantee that none of the information will be shared with law enforcement or federal authorities. So we appreciate you fighting for that. And we'd love to follow-up with you on some of the questions we discussed today. Thank you.

CHAIRPERSON RIVERA: Thank you. I just, I wanted to reiterate that we try to get at some of the privacy concerns and will certainly be advocated for that bill at the state level. Thanks to all of you for all of your work and for bringing up the issues of Department of Health and H&H. And I know we all want to work together to support our community. Thank you to the panel.

SR. POLICY ANALYST EMILY: Yes, thank you to our first panel. Seeing no other questions I'm going to move onto our second public panel. So in order of speaking our second panel will be Farah Salam, Eunhye Grace Kim, and Laurie Huan [sp?]. So Farah Salam you may begin when ready.

SERGEANT: Time starts now.

FARAH SALAM: Good afternoon everybody. I want to thank. I want to begin by thanking the Committee on Health, Committee on Hospitals, and the entire New York City Council for inviting us to comment on budget proposals for fiscal year 2021. My name is Farah Salam and I'm the Community Health and Wellbeing Coordinator at the Arabic American Family Support Center. I'm honored to testify today alongside the 15 percent and growing campaign on behalf of our communities throughout New York City. Our staff speaks 27 languages including Arabic, Fongla [sp?], Russia, Spanish, and Urdu which enables us to serve population that mainstream providers struggle to reach. As a result our agency has remained opened during Covid-19 offering on- service delivery throughout this crisis. We've adapted to social distancing and shelter in place regulations

and have been involving our service provision to best meet the current crisis and emerging needs our crimes faced. Our services are more essential than ever. So we've increased our outreach across programs and launched new initiatives to meet these heightened needs for mental health services and access to health insurance, food safety, amongst other programs. However, Covid-19 has created additional barriers- our organization and the community members we serve. While this disease threatens everyone our communities like the immigrants and refugees we serve face acute difficulties because of preexisting housing, food, and economic instability. Widespread job loss has been, has had a disproportionate impact on our community- in outer borough neighborhoods and presents challenges for the health and safety and stability of thousands. Our communities battle barriers to access high quality healthcare and information. Furthermore because of the antiimmigrant policies and rhetoric that has caused many to feel reluctant about enrolling the services and benefits they need. Our communities are experiencing heightened stress, anxiety, fear, and isolation. And they're suffering in silence due to the stigmas and

these fears. We do everything we can to balance safety with presence for these at risks groups. Our programs continue to maintain contact with 2300 families and more throughout this pandemic. In light of these observations AAFSC- message and mission by joining the 15 percent and growing campaign. We request the city to provide accurate data collection and disaggregation of data on infection rates, hospitalizations, and deaths in the APA community. We must be able to track race and ethnicity and languages spoken for those who are tested so we can appropriately trace and take care of families. Since we are not doing this now our APA communities and our struggles are being erased. We want to ensure that critical information gets to families in the language that they need. It is only recent that Health and Hospitals was able to translate health outreach documents and this was too late and it's still not enough. And lastly we want to address the mental health needs of children and families who have been targeted during this pandemic. There needs to be a system in place that can be prepared to help our communities as they return to daily life. Thank you for this opportunity to testify. As always the Arab

American Family Support Center stands ready to work with you in ensuring that all New Yorkers have access to the services and support that they need to lead healthy safe and fulfilling lives.

SR. POLICY ANALYST EMILY: Thank you for your testimony. We will now turn it over to Eunhye Grace Kim.

EUNHYE GRACE KIM: My name is Eunhye Grace Kim and I'm an Assistant Director at Korean Community Services of Metropolitan New York. We truly appreciate Chair Levine and Rivera and member of the Community of Health and Hospital for giving us the opportunity to share the impact and response to Covid-19 in our communities. 47 years ago KCS became the first social service and nonprofit organization serving the Korean community of New York. Since the pandemic we have seen the need for more services such as home delivered meals, safety check in calls for senior, healthcare complication, and Covid-19 test site coordination. Due to increased demand of service our staff has been working nonstop in helping monthly 7,000 people since March 2020 to target the health inequity. Covid-19 has this special- in our community. Our public health department has

interacted with more than 3,000 people per month about a broad range of issues related to health and healthcare access especially our T2 team that's going out to the field almost every day and reaching out average of 1,000 people weekly. It was inevitable that everyone had to adapt to the new normal whether, which include- services due to the closing of many government agencies and offices. This eliminates the extent our services could provide and created more obstacle with us- clients. For example, Ms. Kim could not go to social security office due Covid-19. To make worse her husband has recently passed away risking her health condition and adding this layer of urgency to see a healthcare provider covered by Medicare. KCS assists her in enrolling in Medicare so that she can see healthcare providers and get proper medication. Therefore in order for us to continue to help client like Ms. Kim we demand the city provide accurate data collection and disaggregation of data infection rate, hospitalization, and that, DPA community. It is critical we be able to track people by race and ethnicity and languages spoken for those who are tested so we can appropriately trace and serve the family most affected by Covid-19. Second,

I'd like to urge the city health- be sure that critical information get to families in languages that they need much faster rate than was when then with on this when Covid-19 first hit. One of our higher demanded services is interpretation service especially for healthcare related issues. We often advocate for our clients' rights and help resolve issue via conference call with third party agencies such as health insurance companies, medical providers, and government agencies. Mrs. Sheen had a conflict with her primary care provider in regards to her health plan coverage. We contacted her PCP and found out that they needed the new Medicare number from a new card. As we, as with many community member with limited English proficiency-

SERGEANT: Time expired.

EUNHYE GRACE KIM: The client did not understand the situation and aware of a new card she was supposed to be given. And we helped Mrs. Sheen request a new Medicare card so that she can continue receiving the health service she needed. Lastly I would like to emphasize the need for mental health service for APA children and families especially those who of- targeted during this pandemic. Mental

health service should readily access- who do suffer from discriminatory and- racist and xenophobic behavior related to Covid-19. Due to rapidly changing circumstances community based organization role are more vital than ever to protect this vulnerable population. The city council must continue to increase their support for CBO. I provided afore mentioned services in communities disproportionately affected by pandemic. Thank you for this opportunity to share our thoughts and experience. We hope that New York City will continue this commitment by considering the suggestions contained. Thank you.

SR. POLICY ANALYST EMILY: Thank you for your testimony. I'll now turn it over to Chair Rivera for questions.

CHAIRPERSON RIVERA: I just, I wanted to ask you, first let me thank you. I know that you've been doing this work for a very long time. You are the exact community based organizations that we mentioned throughout this hearing who have been building, cultivating relationships and trusts with, with people, with very very sensitive backgrounds. You mentioned immigrants and refugees. And so you heard maybe a little bit of the testimony earlier in

the hearing as to some of the frustrations that council members have had. In terms of trying to I guess be more proactive than reactionary. And I wonder what is your, considering your relationship with your community, how has the engagement process been? Not necessarily with your members. I realize the pivot during Covid but with the administration as Health and Hospitals and Department of Health really reached out to you knowing your reputation. How has that all worked out? Anyone can, sorry I didn't pick on anyone specifically.

EUNHYE GRACE KIM: So KCS. Oh, sorry. Oh. So KCS, we are one of the, the teacher partner organization. And even now, right now they're in our- Kew Garden because it's a hot spot right now. So we closely communicate with Health and Hospital. And also we, one time we requested to the Health and Hospital and made ourself is to have a Covid test in our site. So we coordinated a mobile then in September I think two weeks, early September. And we coordinated tested, test like 350 people in our, our CBO building with the mobile. It was really successful. So we requested again to may ourself is to reach out, to provide us another opportunity the

mobile test and the provider community. And I think the, the repery responses and also our T2 team is out there and the H&H hospital and the new city department. Health Department is pretty helpful for us to coordinate all of those events.

FARAH SALAM: Yeah. I can echo some of what Eunhye is saying. We've been working with Health and Hospitals and the Mayor's Office of Immigrant Affairs on the NYC Care Initiative. And through that you know we've gotten a lot of guidance and support. However, one of the things that we consistently you know need assistance with is on providing appropriate language materials which often don't come to us in a timely manner. And this is incredibly important because a lot of the materials that we do get receive, it's probably translated, or it is translated correctly in all ways and shapes. I speak Bangla and I read and write fluently in Bangla. And a lot of the materials that we do receive in Bangla often times are either too proper, so they're like academic Bangla, which not everyone in the community may be able to understand. And another issue is that when, this is an issue with the font itself. When you copy and paste it often, the words get mixed up so

it's not an actual word that gets printed out. And that's something that we've also seen in something like in the census literature throughout the city. And this can be very confusing for our clients and our community members because the information there is not always understandable or understood. And that's where they come to us to help you know have them understand what's happening. You know we've been given blank materials to provide our own information on but sometimes we have to do the extra work and actually retranslate everything again which can take away time from the work that we do in the communities. So that's why the language access is really important. It's not just are we having academic, are we having these translated in proper materials but are we also having them translated in such a way that members of our community who are not as literate as those who are educated can also understand. And then I think that's about it. I hope that answers your question Council Member Rivera.

CHAIRPERSON RIVERA: Absolutely. And I, I'm glad you brought up the census because I remember this happening multiple times and, and I want to thank you all for your work around the census as

well. I know it's technically not over but thank you. I want to turn it over to Chair Levine. You had a question?

CO-CHAIRPERSON LEVINE: Actually just a very brief comment. I want to thank the CBOs on this panel. This is exactly the kind of local leadership we need, deeply involved in not just the delivery but the design of the program. And I want to echo Farah's point on translation. Unlike the work of translating for many other city agencies what we got right now is essentially a real time emergency where new messaging is developed sometimes day to day. And we don't have the luxury of giving a translator weeks to produce good content. So we have to be able to point out good translation within hours of the English, English language original. That's a big big challenge that's going to require resources that they're probably not allocating yet but we certainly join you in the call to help our translation game because we know we have many months to go still in this pandemic. Thank you.

FERAH: Thank you.

SR. POLICY ANALYST EMILY: Thank you so much for your testimony. Seeing no other questions we will now turn it to our last panel. So in order of

speaking it will be Max Hadler and Hayley Gorenberg. So I will turn it over to Max and you can begin when ready.

SERGEANT: Time starts now.

MAX HADLER: Good afternoon. Thank you all very much for the opportunity to testify. My name is Max Hadler. I'm the Director of Health Policy at the New York Immigration Coalition. The NYIC's been involved in a lot of aspects of test and trace. We're a contracted outreach partner. We're designing a training currently for contact tracers on immigrant New Yorker's health access and public charge concerns. And we're a member of the Community Advisory Board. We applaud test and trace for establishing the CAB and subcontracting with CBOs including many of our members to support outreach and resource navigation. We also have remaining concerns as we continue to navigate the pandemic. DOHMH has led the CAB process and helps to relay some of the concerns and confusion that emerged from the mayor's decision to strip the contact tracing efforts from DOHMH's control. But there's still a lack of clarity on where different responsibilities lie which is a major concern in the school reopening process. While

the CABs had meaningful input on several aspects of test and trace, testing and tracing in the context of school reopening has not been a significant source of discussion. And we're unaware of other community advisory processes in forming the reopening process. Additionally the seemingly haphazard creation of the situation room has added to the confusion and we're unclear on how to engage in the process. The rapid and inconsistent pace of change in particularly difficult to navigate for immigrant- families who would be better served by having a clear accountability feedback mechanism that involves education advocates working specifically with immigrant families. On data privacy we appreciate Test and Trace's work- to improve its core message around data protection but we still would like to see stronger public support from the city to urge the governor to sign into law the contact tracing confidentiality bill that Allie alluded to earlier. We're also still in the process of understanding the data security implications of the state's new Covid alert NY apps. We acknowledge that it's a voluntary add on to existing efforts but we're also concerned about the possibility that the app would deepen

inequities if it in any way sidetracks or diverts messaging resources or time to products that are not readily accessible to all New Yorkers regardless of the language they speak or their access to smartphones or other app enabled devices. The city's language access laws are also more expansive and frankly better than the state's so the city should undertake a city specific language access evaluation to be able to equitably use state created apps or tools in addition to considering how disparate tech access to app enabled devices might deepen inequities. And overall more broadly we have to remember that the underlying conditions that have caused immigrant New Yorkers to be disproportionately affected by Covid-19 remain in place. Immigrants represent more than half of the city's essential workforce signifying greater ongoing exposure on documents that- families have been excluded in federal relief programs and many immigrant New Yorkers continue to suffer reduced access to help services during the pandemic because of the state's persistent health insurance discrimination against those without status. An equitable approach to Test and Trace have to account for these disadvantages by

putting these communities first and planning for all subsequent spaces of the pandemic including the eventual distribution of vaccines. Which includes making sure that any prioritizing of essential workers accounts for people who are often not part of the popular imagination of essential and-

SERGEANT: Time expired.

MAX HADLER: -immigrant workers who may be in the informal sector. Thanks for the opportunity to testify. I really look forward to working with you on these issues.

SR. POLICY ANALYST EMILY: Thank you for your testimony. We'll now turn it over to Hayley Gorenberg.

SERGEANT: Time starts now.

HAYLEY GORENBERG: To quote Marry Basset; public health has as its root the commitment to social justice. New York Lawyers for the Public Interest where I'm Legal Director has an inviting and interesting commitment by mission to our community, partners, and clients engaged in fighting marginalization based on race and health disparities fueled by systemic racism all the more clearly a site for peoples' lives in the age of Covid-19. Hiring

thousands of New Yorkers as contact tracers was obviously a key to reaching public health goals. And it also presents an opportunity to infuse jobs into communities most ravaged by a pair of crisis of infection and unemployment. The brief hiring process including the switcharoo from DOHMH to H&H seemed chaotic and- to meet an opening metric costing us the potential for higher effectiveness and equity. I emphasize the point because this was not the city's first rodeo and won't be the last. There will be more opportunities to improve. New York City inexplicably elevated college degrees and professional of public health experience when the World Health Organization and other authorities make perfectly clear that trust and community connection is the pivotal requirement for successful contact tracing and specifically flag that degrees are not needed. Some of the communities hardest hit have longstanding well-known barriers to college education. Prioritizing college degrees and professional experience in this instance undermines public health. And my written testimony includes details of our objections and our examinations of every set of qualifications for contact tracers that we could find in job postings and 15 jurisdictions

around the country including New York state starkly contrasting with what New York City required. The points were unaddressed throughout the brief and intense hiring period. The one official applying that the city ought not to be questioned because it had hired tracers for other public health reasons before so it knew what it was doing. But relying on old systems runs the risk of neglecting modern approaches to HR and it discounts entrenched bias that may pervade hiring systems. And finally subsequently in stark contrast officials helping run the T2 program later distance themselves from the posting and said they didn't know how to come to, exist. So we know public health efforts must address educated mistrust of the health establishment in black and brown communities based on historic abuses. And we know from Doctor Long that seven months into the pandemic we're falling short of linguistic goals and of the stated public health goal of interviewing 75 percent of identified contacts. So anything that unjustifiably screens out people from communities most engaged in the fight against marginalization demands prioritized scrutiny and critique. NYLPI urges the city take the following steps. Overhaul all

hiring bricks to ensure job qualifications match lockstep with job descriptions of what's to be done to avoid excluding people who can do a job well. Searching review is particularly important to ensure traditional frameworks don't carry forward systemic racism and other biases. Assess the city's assertion made as a purported sign of success that more than half of the tracers-

SERGEANT: Time expired.

HAYLEY GORENBERG: Okay. -were hired from hardest hit communities. Why is hiring more than half the tracers from the communities considered successful? Why shouldn't the successful figure be closer to 100 percent? And I'll include more details about that. Conduct any additional T2 hiring using sound guidelines such as those from WHO as a guiding star. And thirdly inquire about the H&H optum split of jobs in the T2 program and make sure outreach for further hiring includes highly effective partnership with community organizations. And just one more point on that partnership of community organizations. Earlier in the pandemic the city reached out to community organizations to form the emergency partner engagement councils working groups in the T2

community advisory board and its working groups. Great idea. Keep it up. Make it more functional. Here are some ideas about how that can happen. Eliminate or coordinate overlap. Epic and T2 Cab both have messaging working groups. Despite inquiries it's unclear to us how it makes sense to have two messaging groups, whether there's any functional demarcation in the work, and whether the work of the two groups is being compared, contrasted, or synergized. Ensure the work product of community members and organizations and these groups is seen, assessed, and incorporated as is useful. And let us know clearly and in a timely fashion that it's being used or ask us for something different. Too often it feels like we're pitching into the void. Address staff turnover and rotations. City staff facilitators for our working groups switch out every few weeks. We're constantly working to reestablish relationships. And the folks who facilitate seem dedicated and concerned and then they're gone. It's a constant parade of apparently well meaning people, especially when we're already having questions about where our suggestions, feedback, and work product go, the perpetual meet and greet further under mine's,

our effectiveness. Thanks for all the good work to date. I include more detailed thanks in my written testimony and thank you for the opportunity today.

SR. POLICY ANALYST EMILY: Thank you. Thank you for your testimony. I will now turn it over to our final panelists Anthony Feliciano.

SERGEANT: Time starts now.

ANTHONY FELICIANO: Can folks hear me. [echo]

SR. POLICY ANALYST EMILY: Now, thank you.

ANTHONY FELICIANO: My apologies. Late- [echo]

CHAIRPERSON RIVERA: You might have something open like maybe the screen or something else.

ANTHONY FELICIANO: Okay [echo]

CHAIRPERSON RIVERA: Sorry, try again.

ANTHONY FELICIANO: It is because I have my phone because I can't have audio. [echo]

CHAIRPERSON RIVERA: Well I would say. I want to definitely hear you. So if the, so if it's something to do with the video and maybe you can only call in I certainly want to hear your testimony without the screeching.

[beeping]

CHAIRPERSON RIVERA: Okay. Well I don't know if he, we lost. Mr. Feliciano I'm sure he will return maybe just with audio. Well in the meantime I want to make sure that. I want to thank you for your recommendations to the previous panelists. And I certainly want to, Chair Levine you had a question?

CO-CHAIRPERSON LEVINE: Well just very briefly, thank you. You brought up so many good points Max. Can you clarify one thing that I think the public needs to know for sure, does getting a city funded Covid test in any way trigger a public charge concern?

MAX HADLER: No. Thank you for the question. And I think, I appreciate every opportunity that we can all provide one another to clarify that. There is nothing about Covid testing or evaluation or treatment that would trigger any additional public charge risk. And also Covid testing and evaluation and treatment are free in New York City and even more broadly in New York state for people who qualify for emergency Medicaid even if they're undocumented and don't qualify for other types of coverage, emergency Medicaid will cover those Covid specific services.

Both a coverage program as well as free services available and in no instance will those services increase someone's-

CO-CHAIRPERSON LEVINE: That is great news and an important to amplify that to the public. Not really a question for Hayley but just a comment to thank you for raising the question of qualifications that are being required so the contact tracers, it really does appear that there, that there are outstanding candidates for these roles from some of the marginalized communities we've been focusing on today who simply can't apply because they don't have the relative required advanced degrees. I've actually specifically heard that in recent days about some of the orthodox communities which as we commented earlier still need additional staffing but I'm sure that's also true for marginalized communities more broadly in this city. So thank you for raising that and, and we join you in the pursuit of reexamining those qualifications so that we really do get the best people in those jobs and people who have deep roots in the communities that are affected. So thank you to NYLPI and thank you Hayley.

CHAIRPERSON RIVERA: And I think you wanted to say something to that point Hayley. I wanted to make sure we unmuted the panelists. And I wanted to just say the previous panel mentioned how even some of the documents were just a little bit too academic and while I think someone with a master's degree can certainly make sure the language is accessible I think it does help to have people from all backgrounds. And before we get to your comment Hayley, I just want to also ask the panel, have, I'm sure you've been in touch with the administration on the data privacy issues and the fears in sharing that, you know with agencies and fear of ICE, etcetera. We heard from NYCLU about a bill that could potentially help that but I'm not sure if you all have received any other information as to how you can reassure your members and as you, as you formulate policies as to that, that data is in fact protected. I just want to make sure we get to you Hayley and I don't know if Max you have anything to add but thanks to, thanks to the panel.

HAYLEY GORENBERG: We have clearly raised the concern about this sort of- not to be revealed except as required by law enforcement is such a big

hole to drive a truck through that people are not reassured. That just, that is not effective in getting the message out. Everybody knows it. And I wanted to actually connect to what, back to saying and to the question about public charge. We do try to be very clear about this and about public charge and being safe from that. But one of the things that we've been raising recently in multiple meetings is that saying free testing is of concern when people walk in and it's not exactly free. It might not be out of your pocket but you're asked to provide insurance if you have it. And then people feel like there's a bait and switch or they're being lied to and that actually there is something that's sort of going on their record that they have to pay or that could otherwise be used against them. And so this sort of free testing, this is not working. We need to be super clear and honest with people about what's really going on. And if not it undermines that trust and willingness to engage.

MAX HADLER: Yeah I would just say on the data security piece I think the single best thing that, that New York state can do and really everyone in New York state has taken the actual- the only

person who refuses to take action is the governor is to sign that bill. Because there's previous evidence in other infectious disease control and with public health surveillance data that shows that you need really strong protections that are specifically related to the data that's being collected for a given issue or a given disease like Covid-19 in order to fully seal off that information from federal authorities. And I don't think anyone needs a reminder about what federal authorities that we're talking about right now. So I think you know wasting time signing a bill that was passed unanimously in both the senate and the assembly is really inexplicable. And while we are encouraging community members to participate in the process and, and working with the administration on the messaging around New York City code being fairly strong around protecting information and also the fact that they don't collect information about immigration status or social security number to be sure about that and to close off the huge hole that Hayley just mentioned we really need to sign this bill into law.

SR. POLICY ANALYST EMILY: Thank you. I think that we may have had Anthony Feliciano call in so I wanted to see if we could- want to participate.

ANTHONY FELICIANO: Yes I have joined by my audio. Sorry about that earlier.

SERGEANT: Time starts now.

ANTHONY FELICIANO: Hi everyone. Sorry my audio was having problems earlier. I'm Anthony Feliciano. I'm the Director of the Commission on the Public's Health System. And I want to thank Councilwoman Carlina Rivera and Councilman Mark Levine and the rest of the council for holding this other hearing and feels strongly that- more of a series of hearings that need to happen on particular issues. I heard a little bit of my colleagues that were speaking and I'm in- with all of them and what they have recommended. I just want to touch on in a few other areas that may have been connected or not because I joined late. We see a mayoral administration with many task forces, many work groups, and there seems to be no real plan how they all align and coordinate. Some duplications I'm seeing including communication messaging- and I'm part of the T2 CAB. So it concerns me that with this

much so called busy work that there's no real coordination and planning so sometimes the plan to plan which concerns me is the community advocate and is a public health professional. The other- of this is with the hospitals. They were supposed to submit that search capacity and pandemic plans and want to know how transparent those plans will be, where the community engagement will occur. And they're really going to address any new searches that will occur. And so those things are critically important in the past. I've seen how submit plans that are plan to plan again but also a cut and paste of previous needs assessments and all that with no real concrete developing in terms of contingencies and remediation. And so that's critically important. The other aspect I think is as we're reopening the city piece by piece I think we're forgetting that- communities face differential exposure and expensive corresponding implications. As if, we said from the get go black and brown communities have been dying disproportionately. We all know why. But somehow every moment we have just part of our reopen, every moment we're thinking about planning with the hospitals it seems to be still and afterthought. And

that's what compounds the tragedy even further. And so those are critically important. I think the other areas to think about, and this is just a little more detailed to figure out how hospitals are taking care, particularly people with asthma and so on because we have, through this, all this Covid remediation of resulting exposure to more toxic cleaning chemicals. So I'm thinking about how doctors and patients come together particularly with children with asthma and so on and how we are addressing that. So in part of any planning we need to think of things that are, we weren't even thinking around before. In order to address-

SERGEANT: Time expired.

ANTHONY FELICIANO: The only think I would add is during this flu season the, confusion that will happen between Covid and flu and then if we're not getting the messaging right just on Covid the more it should be in a more linguistic and confident way we're going to have problems further where people are confused between having the flu or Covid. So I'll end there. Thank you.

SR. POLICY ANALYST EMILY: Thank you for your testimony. We appreciate everybody's time and

their testimony. I just want to see if we've inadvertently missed anyone that would like to testify. Please use the zoom raise hand function now and we'll call on you in the order your hand is raised. Seeing no hands raised I will now turn it over to Chair Rivera because we have concluded public testimony. Thank you.

CHAIRPERSON RIVERA: Thank you so much to everyone who has testified. I want to make sure if Chair Levine if there was anything you wanted to say before I close this out.

CO-CHAIRPERSON LEVINE: No, thank you Chair for excellent work in this hearing, as always. And grateful to all our colleagues and the public who participated. Thank you.

CHAIRPERSON RIVERA: Absolutely. I second that. Thanks everyone for bringing up so many concerns, language access, data privacy, working with our community based organizations and certainly making sure that we are doing this equitably especially for our communities disproportionately impacted. So we have completed public testimony for this hearing. I just want to also mention to the administration just specifically there were some,

some issues brought up for certain communities and neighborhoods, specific data requested. So we're looking forward to following up with you on some of those items and of course to all the public for testifying today. And with that this hearing is adjourned. Thank you so much.

[gavel]

# C E R T I F I C A T E

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


Date October 15, 2020