GREATER NEW YORK HOSPITAL ASSOCIATION
555 WEST 57TH STREET, NEW YORK, NY 10019 • T (212) 246-7100 • F (212) 262-6350 • WWW.GNYHA.ORG • PRESIDENT, KENNETH E. RASKE

February
Twenty-Three
2 0 2 2

Council Member Lynn Schulman
Chair, Committee on Health
New York City Council
250 Broadway, Suite 1866
New York, NY 10007

Council Member Francisco Moya
Chair, Subcommittee on COVID Recovery and Resiliency
New York City Council
250 Broadway, Suite 1768
New York, NY 10007

RE: Statement for Hearing: "COVID-19: Looking Ahead"

Dear Council Members Schulman and Moya:

Thank you for the opportunity to submit a statement on behalf of the Greater New York Hospital Association (GNYHA), which represents more than 140 public and not-for-profit hospitals and health systems in New York State—the majority of them in New York City. GNYHA is proud to serve these hospitals and health systems that, along with the dedicated caregivers who make them run, responded to the pandemic by undertaking the largest mobilization of health care resources in US history—saving thousands of lives and caring for hundreds of thousands of patients.

My statement covers the current status of hospitals as they battle the pandemic and what we may expect in the future.

Where Hospitals Are Now

New York was first hit by the Omicron variant in late November/early December. Omicron is significantly more virulent than previous COVID-19 variants and precipitated an enormous spike in confirmed and suspected cases that dwarfed previous spikes throughout the pandemic. Cases peaked statewide on January 7 at over 90,000. While we are fortunate that Omicron usually presents more mildly than the Delta variant that it supplanted, the sheer number of cases led to a large rise in hospitalizations, which peaked on January 11 at 12,671 statewide at 6,523 citywide. Omicron's retreat has been just as rapid—yesterday there were 1,619 cases statewide, 2,461

hospitalizations statewide, and 882 hospitalizations citywide. Although the Omicron wave has largely passed, it produced the highest number of COVID-19 hospitalizations in the State and City since the spring of 2020 (which peaked on April 12, 2020 at 18,825 statewide and 12,184 citywide) and significantly exceeded the winter 2020-21 wave (which peaked on January 20, 2021 at 9,273 statewide and on February 8, 2021 at 3,884 citywide).

Omicron's virulence meant that more health care workers were simultaneously infected than during previous spikes. This presented hospitals and other providers with staffing challenges during a rise in hospitalizations. As a result, hospitals continue to grapple with health care worker burnout. That is why GNYHA and our members continuously improve existing employee health and wellbeing programs and create new ones. We also support various workforce-related proposals in Governor Kathy Hochul's proposed State budget, including $1.2 billion in health care worker bonuses and workforce training and pipeline initiatives to incentivize the health care workforce to practice in underserved areas.

Since the beginning of the pandemic, hospitals have also improved their patient safety and infection control practices to contain and stop the spread of infectious diseases through environmental cleaning and disinfection protocols. Infection control standards include strict adherence to Centers for Disease Control and Prevention guidance, including screening patients, visitors, and staff at entrances, testing, maintaining a State-mandated 90-day supply of personal protection equipment (PPE), and engineering controls such as adequate air exchanges.

Available COVID-19 treatment options have expanded since the beginning of the pandemic, particularly with the recent introduction of antiviral pills. However, existing monoclonal antibodies were less effective against Omicron infection than against past variants, though new treatments are becoming available. The proven effectiveness, safety, and enormous supply of vaccines make them our most potent weapon against COVID-19. That is why GNYHA and our members supported the State's vaccination and booster mandate for health care workers. Hospitals have administered millions of COVID-19 vaccine doses to New Yorkers and we continue to combat vaccine misinformation and build trust among underserved communities. Using data from the New York City Department of Health and Mental Hygiene to measure social vulnerability among various demographics, GNYHA and our members coordinated with various government agencies to implement vaccination program strategies to reach vulnerable and underserved populations. This builds upon the hospital community's larger efforts to promote equitable care and their recognition that the pandemic has impacted certain communities more than others.

Hospitals take seriously their responsibility to provide respectful, high-quality care to everyone who walks through their doors. This focus on equitable care includes cultural competency training as part of new staff orientation and is built into ongoing training requirements. Hospitals also have special programs that celebrate different cultures and have established diversity councils and employee resource groups to combat things such as implicit bias. GNYHA supports these efforts

and recently provided cultural competence training for almost 2,000 frontline staff and managers from mostly New York City hospitals. Hospitals are also required by the State to maintain language access programs that address patients' needs. Hospitals have a designated Language Assistance Coordinator to implement language access policies and strategies to deliver interpretation services. This has been critically important throughout the pandemic to connect patients to language services in both hospitals and COVID-19 vaccination sites. Hospitals have also leveraged their existing relationships with community- and faith-based organizations, local businesses, and other community anchors in culturally and linguistically appropriate ways to provide information to their communities about the importance of COVID-19 safety and vaccines.

Although we are now past the Omicron wave and nearly two years into the pandemic, GNYHA and our member hospitals remain worried that New Yorkers continue to delay their care. That is why we have run ad campaigns (www.gnyha.org/safecare) to reassure people that hospitals are safe and they should prioritize their health. Even during the worst of the pandemic, emergency services and procedures have remained available. We are also making every effort to ensure that non-urgent services remain available during potential future surges.

Preparing for the Future

Although we have learned not to predict where the pandemic may bring us, we can anticipate and prepare for future spikes based on data showing COVID-19's seasonal patterns. While we expect cases, hospitalizations, and deaths to continue to drop in the near future, we remain alert to the possibility of future variants with greater vaccine escape and transmissibility, relaxed public health measures, and future winter spikes. Omicron's milder symptoms were offset by its high transmissibility, which once again strained hospitals. It is important that the health care community, public officials, and the media effectively communicate this information to the public rather than provide them with false hope that may once again burden hospitals.

Nevertheless, New York's hospitals have now managed several major COVID-19 waves and are increasingly adept at rapidly expanding and reducing capacity, as necessary. They can swiftly add beds, staff, and equipment to meet rising hospitalizations. The State has also suspended non-urgent surgeries in specific scenarios, but hospitals continue to prioritize scheduled and medically necessary procedures such as cancer-related surgeries. The State can provide greater flexibility for patient transfers between hospitals and health systems and can suspend utilization review to increase the availability of health care staff who can perform patient care duties. The State can also expand scope of practice for certain health care workers and authorize, retired, and recent or nearly graduated health care workers to practice when providers face staffing challenges. Individual hospitals and health systems also have their own contingency plans to manage staffing challenges.

As hospitals prepare for the future, they also face grave threats from the severe financial costs of multiple COVID-19 surges, reduced patient volume, and Medicaid reimbursement rates that don't come close to covering the cost of care. That is why GNYHA is advocating in Albany for more

investments in 1) New York's heroic health care workforce, 2) Medicaid rates that have been frozen for 14 years, and 3) financially struggling safety net hospitals across the five boroughs so they can thrive rather than just survive. We are encouraged by the major health care investments in Governor Hochul's proposed State budget and hope to build upon them. We would welcome the City Council's support for increased investments in New York's hospitals and health care systems as they continue to recover from the pandemic.

Conclusion

We recognize and share the eagerness to put the pandemic behind us, but we are not there yet. COVID-19 is here to stay and will periodically threaten hospitals and their patients. Reluctance, hesitance, or hostility toward necessary public health measures may jeopardize hospital capacity and their ability to provide care to those who need it most. All of us must keep our guard up by effectively communicating and informing people of the necessary measures to protect New York's hospitals, their valiant workers, and the patient they serve.

GNYHA and our entire membership are strongly committed to ensuring that our health care system and New Yorkers emerge from the pandemic stronger and healthier than before. We appreciate the City Council's interest in this issue and look forward to working together to facilitate New York City's recovery from the pandemic.

If you have any questions, please contact David Labdon (dlabdon@gnyha.org) or Andrew Title (atitle@gnyha.org).

Sincerely,

David Labdon
Director, Government Affairs

TESTIMONY OF LILLIE CARIÑO HIGGINS
BEFORE THE COMMITTEE ON HEALTH JOINTLY WITH THE
SUBCOMMITTEE ON COVID RECOVERY AND RESILIENCY
FEBRUARY 23, 2022

Thank you, Speaker Adams, Chairpersons Schulman, Moya and members of the Committees for this opportunity to testify before you today. My name is Lillie Cariño Higgins, and I am here on behalf of close to 250,000 health care workers, members of 1199 SEIU, residing and working in New York City. Our members work in the municipal and voluntary hospital systems, nursing homes, FQHCs, community-based organizations, mental health clinics, in the home care industry, pharmacies, EMS, and even New York City jails, including Rikers Island.

COVID-19 has taken its toll on health care workers, creating a serious workforce shortage in all industries. Our members have testified here in the past, and they will tell you that the exodus is not due to fear of actual pandemic, but to working conditions. It is our view that if steps to recruit and retain a stable healthcare workforce are not implemented immediately, New York City will reach a crisis point in the very near future, with dire consequences.

This is why 1199 applauds and urges the City Council to support Gov. Kathy Hochul's proposed $10 billion multiyear plan to fund new initiatives that support the healthcare industry. The proposal includes funding for workforce recruitment and retention to ensure long-term stability. The Governor's proposal provides a one-time $3,000 retention bonus for workers who remain in the field for one year (prorated for part time workers) and a 5.4% COLA (cost of living adjustment) increase. We ~~are also~~ also urge the Council to make sure the bonus is available to ~~all~~ every title of health care workers as they all put themselves at risk during the pandemic. Whether they ~~such as those who~~ prepare food, clean rooms, transport patients, ~~and~~ or ~~do the~~do ~~laundrey~~laundry, or if they test lab specimens, take x-ray's, or provide respiratory therapy, all workers were vulnerable, risked their lives, and worked under extremely stressful circumstances day after day.~~as they all put themselves at risk during the pandemic.~~

Most important, the Governor's proposal calls for an increase in the Medicaid reimbursement rates, rates that have been stagnant – despite significant rising costs – for over 20 years.

Many of our members were themselves exposed during the early days of the pandemic and feared exposing their loved ones. They stayed in hotels and made other living arrangements that separated them from their families. Still, they showed up and returned to work ~~every day~~daily, often after just a few hours of sleep, because of their commitment to helping the sick and vulnerable. It's their calling and they do this work out of conviction, a deep sense of caring, and compassion.

COVID-19 exacerbated staff shortages and adverse working conditions in each of our industries in unique, yet very similar, ways. For example:

*__Hospitals__ are working at overcapacity. We represent over **110,000** municipal and voluntary hospital workers who were already short-staffed before COVID-19. For the past two years, our members worked double shifts, 16–24-hour days, at times just taking short breaks to rest, without seeing their families for weeks or months at a time, while losing multiple patients, day after day. Exhaustion and burnout ensued. Even those that do not have direct patient contact had their workloads and responsibilities increase significantly.

Governor Hochul's Executive Budget proposal includes an additional $100 million in support for safety nets hospitals. This number, however, is based on the previous administration's approach of providing hospitals serving the needy with just enough additional cash to keep their doors open. This keeps institutions in perpetual crisis, juggling which creditor to pay first and unable to borrow money or make any needed investments in services or staff.
Some of our anchor institutions – including Montefiore Health System, which provides 70% of all the care in the Bronx – are in real danger because of the chronic underfunding of Medicaid. **Our state's safety net hospitals need an additional annual investment of at least $500 million state share in order to stabilize and begin to rebuild.** We strongly urge the Council to support additional funding for the safety net hospitals.

*__Nursing homes__ were hit extremely hard. The death toll was staggering. **42,000** 1199 members working in these facilities were on lockdown. Initially, workers and residents were without proper gear, and we are grateful to the state for responding to the urgent need to get equipment and PPEs to these facilities. Our members made efforts to keep their residents in touch with their relatives via phone and video conferencing to minimize isolation, often using their personal devices because most facilities are not equipped with such technology. While attending to resident needs, they sought to keep residents entertained to compensate for lack of visitors, all while monitoring each resident for depression, infection, and other health issues. Our nursing home members became family substitutes amid alarming contamination rates.

Last year, nursing home workers and advocates worked with the Legislature to enact comprehensive reform legislation to set a minimum level of staffing and ensure that public dollars are spent on resident care and staffing rather than siphoned off to excess profit and administrative costs. Governor Hochul has enacted an Executive Order pausing enforcement of these laws to respond to the Omicron surge. We ask the Council to urge Governor Hochul to fully implement these reforms now that the surge has passed.

*__60,000 Home Care__ workers were true s/heroes. They traveled far and wide at great risk to ensure those needing care at home avoided transfers to nursing homes. We applaud the city for responding to our plea for PPEs for both our members and their clients. Their dedication and commitment to their clients are inspiring. That said, we urge the City Council to support in the budget "Fair Pay for Home Care" legislation which mandates that home care workers are compensated at 150% of the minimum wage.

*__FQHC/CBOs__ have historically experienced severe hardship in recruitment and retention. Our **6,000** members have achieved licensure and certification requirements equal to those of acute care facilities, but have yet to attain wage parity. For example, a certified social worker at an acute care facility will be compensated at a much higher rate than reimbursement rates allow for a CBO, a difference of tens of thousands of dollars. These ~~community based~~community-based facilities experienced significant increases in demands for substance abuse and mental health services by patients fearful of hospitals.

***Pharmacy** workers were also hard hit. **4,000** 1199 members will attest to the great pressure to meet high demands with scarce resources. Workers went without PPEs as employers sought to address supply shortages. This produced great stress and increased tensions with customers who themselves needed supplies~~, who~~ and endured long lines only to find that the pharmacies ran out of alcohol, swabs, sanitizers, masks, gloves, and other essential supplies that both staff and customers required.

Health care will remain a competitive field. It remains the fastest growing industry. Yet, the COVID-19 demonstrated serious deficiencies that we must work to correct before we face another health emergency. We must invest in health care infrastructure to ensure emergency preparedness for the next crisis. As examples:

* Medicaid reimbursement rates must increase. It is outrageous that a CNA or a home health aide required to obtain specialized certifications are working for wages that qualify them for entitlements. This is shameful. We must do better to get these workers a living wage.

* 1199 calls state and city leaders to ensure bonuses are paid to workers in the event of future prolonged health crisis when called upon to fill staffing voids, particularly when it necessitates they work double shifts and excessive overtime.

*We must attain wage parity for CBOs with salaries in acute care facilities.

*The City must develop an emergency preparedness plan, that includes sufficient supplies of PPEs in the event of a future outbreak of an airborne pandemic.

*Student loan forgiveness programs for workers after a set number of years of service in health care must be established to entice recruitment. In addition, reduced tuition and scholarships should be available for students enrolling in any CUNY and SUNY health care programs.

*Recruitment incentives should also be available for language and cultural competency with a goal toward improved care outcomes.

*Mental health must be viewed as a health issue. This became quite evident during the pandemic, where fear of exposure in hospitals caused too many individuals to discontinue care. Many decompensate and end up in correctional facilities that are ill-equipped to provide proper uninterrupted long-term care.

In sum, COVID-19 exposed the lack of long-term planning needed to address emergencies. Health care inequities in communities of color were highlighted, not just in New York City but across the globe. Access to resources often depended on ZIP Codes to the detriment of communities of color. Providers and communities must be engaged to ensure a constructive dialogue ensues toward ameliorating any future crisis. Whether it was access to vaccines and testing, to food and services, we must make this a learning opportunity to correct deficiencies.

This Council can play a major role in the future of healthcare and we at 1199 stand ready to work with and collaborate with you on how better to meet the needs of New Yorkers. We look forward to working with you and look forward to a more in-depth dialogue.

Again, thank you for this opportunity to testify before you today.

अधिकार
adhikaar

71-07 Woodside Ave.
Woodside, NY 11377
(718) 937 - 1117

Adhikaar for Human Rights and Social Justice
Testimony submitted to Subcommittee on COVID Recovery and Resilience *(Jointly with the Committee on Health)*
Preliminary Budget Hearing for FY23
February 23, 2022

Good morning, my name is Prarthana Gurung and I am the Director of Campaigns and Communications at Adhikaar. Adhikaar is the only immigrant women-led worker and community center serving and organizing the Nepali-speaking community on workers rights, immigrants rights, access to healthcare and language justice. We are often referred to as our community's 911 and 311 line, serving more than 10,000 Nepali-speaking people a year. Our community is one of the newer immigrant communities and according to Asian American Federation's 'Profile of New York City's Nepal[i] Americans' report, the fastest growing Asian ethnic group. Most of our members are women who work in the informal sector as nail salon workers, domestic workers, taxi drivers, and restaurant workers. They mostly live in Jackson Heights, Woodside, East Elmhurst, Elmhurst, Corona, Maspeth, Sunnyside, Ridgewood, Jamaica and Flatbush.

At Adhikaar we engage in multi-sectoral organizing, services, and advocacy to transform low-wage industries and advance the rights of immigrant women workers, particularly nail salon and domestic workers. Through these programs our members gain the leadership and skills to engage in collective decision making and advocate for policies that recognize and center the dignity of immigrant workers. For too long, the struggles and demands of communities like ours–immigrant women workers in low-wage industries– have been rendered invisible. As we reimagine a just recovery for all New Yorkers, it is essential that the voices and experiences of our community are recognized and respected. Workers' rights is every part of health justice.

I have worked in this industry for 7 years and I have invested so much in my skills as a technician. I feel like there is so much pressure on workers to make sure the salon profits when I know that there are other reasons why it is not doing well - there are barely any customers now, we still depend on tips, and the owner can't make a profit. Especially after COVID-19 I have thought about leaving the industry, but then I remember that this work is how I've been able to support my family, and I have found a home with Adhikaar and the other members. Yes, there are lots of problems like health and safety problems too and I am afraid of going to work sometimes, but I think we can make this a better industry, not just for ourselves but for everyone. - **Maya B., Adhikaar Worker Leader and Adhikaar's Nail Salon Workers' Association Vice Chair**

Two years ago we were in the epicenter of the first wave of the pandemic. Thousands of community members reached out to Adhikaar seeking support. To meet their urgent demands we quickly transitioned our operations remotely and ran a robust COVID-19 community response that has supported more than 10,000 Nepali-speaking immigrants through direct services and mutual aid, community education, organizing, and advocacy. Our member-led committees organized direct emergency relief funds to members, distributed PPE and food to workers, and facilitated unemployment

insurance support through our Unemployment Insurance clinic. We also invested deeply in the digital literacy of our members to empower their accessibility and engagement with online communication tools and platforms. This enabled our workforce development trainings to continue and ensured our members participated and led our advocacy campaigns to advance the rights of low-wage immigrant women workers.

On the advocacy front, our nail salon workers and allies from the New York Healthy Nail Salons Coalition joined New York State Senator Jessica Ramos and Assemblymember Harry Bronson in introducing the Nail Salon Minimum Standards Council Act. The first of its kind in the United States, the legislation would 1) create a nail salon industry council made up of workers, employers, and government officials that would collectively come up with recommendations to send to the NYS DOL Commissioner to improve standards industry wide. Our domestic worker members are also pushing to implement Int 339, a historic city council legislation that provides human rights protections to domestic workers at the workplace.

Adhikaar has always supported me and given me opportunities to succeed. I feel proud to be able to support other domestic workers. I took the nanny training at Adhikaar in 2018 and became a trainer recently. I now train other domestic members and I am happy to join Adhikaar as a Fellow in the past. I know so much more about what I can do when there is injustice now than I did before. I am also a TPS holder and was part of the TPS Core Committee. In February [2019], I shared my story at a big rally and I was really scared and emotional. I was happy that I got to speak alongside my Congresswoman, Alexandria Ocasio Cortez. I know that our stories are what made the Dream and Promise Act possible.

- Rukmini, Domestic Worker Fellow, and TPS holder

-

Despite these holistic efforts, the impacts of the pandemic continue to reverberate across our community. Our members face significant economic, health, and food insecurity, and report rapid changes in their industries from working conditions to pay shifts, as well as members taking up employment in multiple industries. In response, we are creating industry specific English for Empowerment (EFE) curriculums to ensure our member-workers have the language and literacy skills necessary to navigate their workplaces. Our workforce development courses have also been adapted to online and in-person format. This includes our NYCOSH Beauty School in partnership with NYCOSH and WU where we utilize a workers-rights based curriculum in Nepali and Spanish, with trainings led by peer worker trainers, as well as our “We Rise” nanny training program in collaboration with Cornell ILR and the National Domestic Workers Alliance-NY. This is critical as our members have been asked to work longer hours and are battling lower wages etc. Our member workers are gaining the skills and resources to negotiate better working conditions for themselves and their peers.

To better understand the state of the low-wage industries and its impact on our members, we partnered with Cornell to conduct research on how conditions were changing at the workplace. This research will be published next month and will provide data necessary to improve industry conditions for both workers and employers. There is also a new terrain of worker health risks emerging that necessitate our attention. A recent study from the University of Toronto found that nail salon workers’ exposure to chemicals was 30 times higher as compared to exposure within households from everyday products. It’s important that these health and labor conditions are taken into consideration when designing recovery policies geared towards low-wage immigrant workers.

This is a snapshot of work in ensuring that the experiences and demands of Nepal-speaking workers and other low-wage immigrant communities are part of recovery policies. To meet the demands of our growing community and our unique approach to multi-sectoral service and organizing, we are requesting XXX in FY23 discretionary funding. This will ensure that our growing community in New York City not only survives, but thrives.

Thank you for your time and consideration.

Testimony of the American Heart Association

Before the New York City Council Committee on Health
and the Subcommittee on COVID Recovery and Resiliency

February 23, 2022

Greg Mihailovich, Community Advocacy Director
American Heart Association, New York City

Thank you, Chair Schulman, Chair Moya, and the members of the New York City Council Committee on Health, and the Subcommittee on COVID Recovery and Resiliency. On behalf of the volunteers of the American Heart Association, we are grateful for the opportunity to present testimony related to key health initiatives that our organization believes will support healthy behaviors in New Yorkers.

As the nation's oldest and largest voluntary organization dedicated to fighting heart disease and stroke, of which approximately 80% of diagnoses are preventable[1], we believe every person deserves the opportunity for a full, healthy life. Our mission – *to be a relentless force for a world of healthier, longer lives* – is more important than ever.

The COVID-19 pandemic has underscored the serious gaps in our public health infrastructure because of years of chronic underfunding. Black, Latino, LGTBQ, and other medically underserved populations are more likely to have chronic conditions including heart disease, hypertension and diabetes that may put them at higher risk for COVID-19 complications. They also are more likely to face systemic obstacles to good health, such as lack of access to quality care, jobs, education, and housing, that can have devastating consequences in the face of a public health emergency. A strong public health enterprise that prevents and protects all individuals and families living in New York City from all diseases and preventable conditions—communicable and noncommunicable—requires robust, sustained investment.

As you begin the process for the first budget of this term, we ask that you prioritize funding for programs and initiatives that address these systemic health inequities.

Increasing Access to Care

NYC must continue to invest in community health centers, which provide essential care to medically underserved populations and are trusted messengers because they are

[1] "Preventable Deaths from Heart Disease & Stroke." Centers for Disease Control and Prevention, Centers for Disease Control and Prevention, 3 Sept. 2013, www.cdc.gov/vitalsigns/HeartDisease-Stroke/index.html.

part of the fabric of the community. We should also expand telehealth services so patients can access care regardless of where they live. Because of the pandemic, millions of New Yorkers have turned to telehealth to meet their medical needs. This could be a positive development because telehealth increases access healthcare to those who ordinarily lack it, increases medication adherence protocol, and allows patients to be monitored and treated continuously within the comfort and privacy of their own home. Unfortunately, many New Yorkers face additional barriers to accessing telehealth. If someone is living on a fixed income, they may not have the financial resources to afford devices or internet service fees. They may not know how to use the technology and lack the assistance to learn. People with hearing loss, impaired vision, or language barriers will struggle even more.

Providing greater access to health care in someone's community, or their home, is a major step in achieving health equity.

Reducing Food Insecurity

The devastating economic impact of the pandemic means that there is no more important time to assure there is a robust food safety net. New York City made significant investments in GetFoodNYC, Grab-and-Go meals, Health Bucks and Get the Good Stuff to help keep New Yorkers fed and provide access to affordable healthy food. Food assistance programs are critical for reducing disparities across race/ethnicity, income, and geography. Unfortunately, nearly 1.6 million New Yorkers - one in five - are facing food insecurity.[2] That includes school children, seniors, parents, and working adults.[3] Every family should have access to the foods that help support a balanced diet and a healthier life. The American Heart Association supports appropriations and any necessary adjustments to these programs to assure they are optimally effective, and that they are providing access to healthy, affordable foods. Higher intakes of fruit and vegetables – at least 2 daily servings of fruit and 3 daily servings of vegetables – have been associated with lower mortality.[4]

Expanding the reach and impact of these effective initiatives will have significant long-term health and economic benefits for New York City.

Living Tobacco Free

According to the World Health Organization, smokers are likely more vulnerable to severe and potentially life-threatening cases of COVID-19. Smokers often suffer from lung disease and reduced lung capacity, which would greatly increase the risk of serious complications from COVID-19 infection. While there is currently no direct data about the role of vaping in COVID-19 infection or outcomes, a growing body of

[2] NYC Mayor's Office of Food Policy. (2021). Food Forward NYC: A 10-Year Food Policy Plan. https://www1.nyc.gov/assets/foodpolicy/downloads/pdf/Food-Forward-NYC.pdf

[3] Ibid.

[4] Wang, D. D., Li, Y., Bhupathiraju, S. N., Rosner, B. A., Sun, Q., Giovannucci, E. L., . . . Hu, F. B. (2021). Fruit and vegetable intake and MORTALITY: Results from 2 prospective cohort studies of us men and women and a meta-analysis of 26 cohort studies. Circulation. doi:10.1161/circulationaha.120.048996

evidence shows that vaping can harm the health of your lungs. While more research is needed, limited evidence suggests that using e-cigarettes may suppress your immune system, making you more susceptible to respiratory infections and delayed recovery.

The growing evidence around tobacco and e-cigarette use and adverse outcomes from COVID-19 has strengthened the American Heart Association's position that we need New Yorkers to quit their addiction as urgently as possible. With the enactment of the city law banning all flavored e-cigarettes – hopefully to be soon followed by companion legislation restrict access to all flavored tobacco products, including menthol – New York City needs to invest in more cessation programs and support for those now struggling with a nicotine addiction because of heavy e-cigarette use. Those cessation resources also need to available virtually or online to be easily accessible during for these socially distant times.

Expanding local tobacco and nicotine cessation programs will help many New Yorkers live longer and healthier lives.

Thank you for everything you have done and will do to protect the lives of the people of New York City. The American Heart Association is a reliable and trusted source of information based in credible science, and we will continue to be your partner in ensuring the health and well-being of all New Yorkers.

CACF
Coalition For Asian American Children+Families

New York City Council
Committee on Health
February 23, 2022

Testimony of Medha Ghosh, MPH, Policy Coordinator
Coalition for Asian American Children and Families (CACF)

Good afternoon, my name is Medha Ghosh and I am the Health Policy Coordinator at CACF, the Coalition for Asian American Children and Families. Thank you very much to Chair Schulman and Moya for holding this hearing and providing this opportunity to testify.

Founded in 1986, CACF is the nation's only pan-Asian children and families' advocacy organization and leads the fight for improved and equitable policies, systems, funding, and services to support those in need. The Asian American Pacific Islander (AAPI) population comprises nearly 18% of New York City. Many in our diverse communities face high levels of poverty, overcrowding, uninsurance, and linguistic isolation. Yet, the needs of the AAPI community are consistently overlooked, misunderstood, and uncounted. We are constantly fighting the harmful impacts of the model minority myth, which prevents our needs from being recognized and understood. Our communities, as well as the organizations that serve the community, too often lack the resources to provide critical services to the most marginalized AAPI New Yorkers. Working with over 70 member and partner organizations across the City to identify and speak out on the many common challenges our community faces, CACF is building a community too powerful to ignore.

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

This report highlights the disproportionate impact COVID-19 pandemic has had on the New York Asian American community that requires acknowledgement and equitable support and resources to support our communities in ongoing COVID-19 relief and recovery efforts. Our community-based organizations have had to pivot to provide basic needs and resources to our community members, including timely COVID-19 prevention and vaccination information in preferred languages, language/interpreter services to link communities to appropriate social services and public benefits, and food support to increase food security. These issues remain largely unaddressed by local, state, and national leaders in the COVID-19 emergency response efforts.

Our survey found, 75% of the participants reported having received at least one dose of the vaccine; but there were notable differences by subgroup. Bangladeshi and Nepali adults reported having the lowest vaccination rate compared to other Asian subgroups; however, they had high COVID-19 vaccination acceptance (as in, they reported they were 'somewhat or very likely' to get the COVID-19 vaccine). In other words, the lower uptake of vaccines among Bangladeshi and Nepali adults in the NYC area may be attributable to COVID-19 vaccination access, not to hesitancy. Efforts to provide access to vaccinations should continue for all Asian American groups as acceptance seems high, but Bangladeshi and Nepali adults should be priority populations in COVID-19 vaccination efforts.

CACF
Coalition For Asian American Children+Families

This is due to factors such as a lack of properly translated written materials on vaccine information and a lack of on-site interpreters in locations that provide the vaccine.

Asian American adults face language barriers and insufficient access to interpreters and written materials in their preferred language, which poses barriers to accessing health care and mental health care resources, COVID-19 relief benefits, and their long-term, overall health and well-being. Language access to COVID-19 related information is particularly important for individuals whose primary language is not in English. The COVID-19 pandemic has intensified the need for appropriate access to COVID-19 materials and written information in patient preferred languages and interpreters to ensure public health guidance is widely accessible to everyone. Our survey found 1 in 3 (34%) Asian American adults reported language barriers being a challenge during the pandemic.

Chinese, Korean, and Bangladeshi adults reported high rates of difficulty waiting for an interpreter, while Korean, Japanese and Other Asian adults reported high rates of getting written materials in their preferred languages. Language services and translated written materials in health care and public service settings should expand to ensure equal access to care.

For the Asian American community, our major recommendations are:

- Improving COVID-19 vaccination access
- Expanding language access and services for COVID-19 efforts and social services
- Expanding eligibility (citizenship and part time employment status) for benefits and extending eviction moratorium
- Financial support for Asian American serving community-based organizations

The findings from this survey emphasize the need for more intentional collaboration between the City and community-based organizations to both better identify the needs of our communities and the solutions that will have a direct impact on our communities.

Thank you very much for your time.

CENTER FOR Science IN THE Public Interest

The nonprofit publisher of Nutrition Action Healthletter

Testimony of the Center for Science in the Public Interest
Dr. DeAnna Nara, Senior Policy Associate
before the
New York City Committee on Health & Subcommittee on COVID Recovery and Resiliency
on
Oversight - COVID-19: Looking Ahead
February 23, 2022

On behalf of the Center for Science in the Public Interest, thank you for the opportunity to provide testimony to support the recovery and rebuilding efforts in New York City in the wake of COVID.

As of today, New York city has lost almost 40,000 people to COVID-19[1] with thousands left suffering from long term illness and other complications. We know that chronic disease has played an important role in these outcomes and that adults with chronic conditions including diabetes, heart disease or stroke, overweight or obesity, and cancer, are more likely to get severely ill or die from COVID-19[2] with one study estimating that almost 2 out of 3 COVID-19 hospitalizations in the United States were attributable to diabetes, obesity, hypertension, and heart failure.[3]

Reducing the burden of chronic disease should remain a critical focus as we attempt to rebuild and prepare for future pandemics. As the city's leadership looks to heal and rebuild communities in the wake of such devastating loss and suffering, it is important to consider one of the largest influences on chronic disease- nutrition and the built food environment.

Access to healthy food should be attainable for all New Yorkers, regardless of income, race, or education, and yet too many people still struggle to eat healthfully because of barriers in the food environment[4], barriers that the pandemic has only worsened.[5,6] Neighborhood food environments play a major role in shaping dietary behaviors, especially those environments with a high density of fast-food chains.

Having greater access to fast food restaurants contributes to poor diet quality[7] and New York City has over 2,000 chain restaurants[8], many of which are concentrated in Black and Latino neighborhoods. These restaurants consistently offer unhealthy foods and drinks that are saturated with added sugars and sodium, making it nearly impossible for consumers to eat these foods while also maintaining a healthy diet. To compound that, chain restaurants spend billions of dollars to aggressively market to marginalized communities, especially to children and teens. In 2019, chains such as McDonald's, Domino's, and Taco Bell, spent over $1.5 billion on TV ads to target Black and Hispanic kids and teens, and almost all these fast-food ads promoted full-calorie, adult-sized, regular menu items, not kids' meals.[9]

Meanwhile, diabetes and obesity rates are increasing at an alarming rate — not only among adults, but also among children. New York City experienced a 356% increase in diabetes-related deaths during the first wave of COVID-19, the largest increase in any urban area in the nation.[10] These numbers are just added on to an existing crisis: one New York City resident was already dying every 90 minutes from diabetes-related causes prior to the pandemic.[11]

Added sugars play a big role in that crisis. Unlike naturally occurring sugars found in fruits and veggies, added sugars are concentrated sugars added to processed foods and drinks to make them more palatable, providing empty calories without the filling fiber or beneficial nutrients that come from whole, unprocessed foods.

There is strong and consistent evidence that shows the intake of added sugars from foods and/or sugary drinks is associated with excess body weight in children and adults. [12] Sugary drinks also contribute to type 2 diabetes and heart disease—in part because they lead to weight gain[13].

Most recently, the city council took a major step on the path to rebuilding a healthier New York with the passage of INT-1326B, also known as The Sweet Truth Act, a bill that requires chain restaurants (those with 15 or more locations nationally) in New York City to post added sugars warning icons on prepackaged food or drink items that contain more than an entire day's worth of added sugars (50 grams). No other U.S. jurisdiction to date has successfully implemented warnings for foods and drinks that are high in added sugars.

While we celebrate this historic victory, in its current form the bill tells only part of the truth about the sugar-laden offerings at chain restaurants, because it fails to cover fountain drinks and other non-prepackaged items that are prepared on site. That means if the bill goes into effect in its current form, a New Yorker walking into a restaurant chain like Subway would see warnings on the 20-ounce bottled soda, but not on the fountain sodas, which could contain as much or more added sugars. And we know from a recent report released by the Center for Science in the Public Interest (CSPI) that most "small" fountain drinks sold at the top fast-food chains contain more than a day's worth of added sugars, leaving some of the biggest offenders without a warning.

That is why warnings under the Sweet Truth Act must be extended to cover all high-added sugars items served in chain restaurants, including fountain drinks. Expanding this policy before it goes into effect remains an urgent priority, with no time to waste implementing half measures.

As communities across the city seek to rebuild and recover from the pandemic, the food industry should be held accountable and rise to the challenge by providing consumers with all the information they need to stay healthy.

Thank you for the opportunity to testify on this important issue. We look forward to supporting New York city in its rebuilding efforts and applaud the steps that the city has taken to put progressive public health initiatives in place.

For questions or more information, please contact Dr. DeAnna Nara at dnara@cspinet.org.

[1] https://www1.nyc.gov/site/doh/covid/covid-19-data-totals.page
[2] Centers for Disease Control and Prevention. People with Certain Medical Conditions. COVID-19. https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html.
[3] Hearn M, et al. Coronavirus Disease 2019 Hospitalizations Attributable to Cardiometabolic Conditions in the United States: A Comparative Risk Assessment Analysis. *J Am Heart Assoc.* 2021;10:e019259.
[4] Centers for Disease Control and Prevention. Healthy Food Environments. February 2, 2021. https://www.cdc.gov/nutrition/healthy-food-environments/index.html.
[5] Nagata JM, et al. Perspective: The Convergence of Coronavirus Disease 2019 (COVID-19) and Food Insecurity in the United States. *Adv Nutr.* 2021; 12:287-290.
[6] Parekh N, et al. Health behaviours during the coronavirus disease 2019 pandemic: implications for obesity. *Public Health Nutr.* 2020;23(17):3121-3125.
[7] Rummo, P. E.,et al. (2017). Understanding bias in relationships between the food environment and diet quality: the Coronary Artery Risk Development in Young Adults (CARDIA) study. Journal of epidemiology and community health, 71(12), 1185–1190. https://doi.org/10.1136/jech-2017-209158
[8] https://nycfuture.org/pdf/CUF_StateoftheChains_2020_final.pdf
[9] https://media.ruddcenter.uconn.edu/PDFs/FACTS2021.pdf
[10] Woolf SH, et al. Excess Deaths From COVID-19 and Other Causes, March-April 2020. JAMA. 2020;324(5):510–513. doi:10.1001/jama.2020.11787
[11] https://www1.nyc.gov/assets/doh/downloads/pdf/epi/databrief28.pdf
[12] de Ruyter JC, et al. A Trial of Sugar-Free or Sugar-Sweetened Beverages and Body Weight in Children. N Engl J Med. 2012;367(15):1397–406.
[13] Malik VS, et al. Sugar-sweetened beverages and cardiometabolic health: An update of the evidence. Nutrients 2019;11(8):1840

NYC Council Committee on Health and Subcommittee on COVID Recovery and Resiliency
Public Hearing: Oversight - COVID-19: Looking Ahead
February 23, 2022

The Community Health Care Association of New York State (CHCANYS) is grateful for the opportunity to provide written testimony to NYC Council Committee on Health and Subcommittee on COVID Recovery and Resiliency. CHCANYS is the statewide primary care association representing New York's 70+ federally qualified health centers (FQHCs), also known as community health centers (CHCs).

Located in medically underserved communities, CHCs provide high quality primary care to everyone, regardless of ability to pay, insurance coverage, or immigration status. NYC's community health centers serve 1.2 million patients at 490 sites in the communities hardest hit by COVID-19. Community health centers are a vital safety net for quality affordable healthcare services for many New Yorkers who otherwise wouldn't have access to healthcare. Among NYC health center patients, 40% are Hispanic, 33% are Black, 17% are White, and 10% are other people of color.

Disparate impact of COVID-19 on communities of color

The COVID-19 pandemic has exposed and exacerbated the longstanding inequities that low-income communities, communities of color, and people with comorbidities have faced for years. Due to the pervasive structural inequities that CHC patients regularly encounter, they are at the highest risk for severe negative health consequences resulting, not only from COVID-19, but also from a lack of access to health care and social support services generally. For New Yorkers who otherwise wouldn't have access to healthcare services due to being uninsured or underinsured, their immigration status, or lack the ability to pay, community health centers provide life-saving quality healthcare services.

CHCs are trusted by their communities, making them a high value source of care in communities who have a long history and good reason to distrust traditional healthcare systems. Communities trust health centers because they are community-run, with over 50% of Board members comprised of patients of the health center. Moreover, CHCs hire staff from the very communities they serve. The providers, nonclinical staff, and patients patronize the same grocery stores, have children who attend the same school, and ride the same transit lines. The trust between CHCs and the communities they serve has enabled CHCs to address health issues as they arise in the community. Beyond providing healthcare services, many CHCs also act as a center for connecting patients to services to address social needs, understanding that addressing social determinants health is key to improving health and reducing health disparities. However, it is clear that more work needs to be done to advance health equity and ensure that all New Yorkers are connected to high quality comprehensive care.

Lessons learned and support needed in future pandemics

Throughout the pandemic and into today, CHCs have conducted thousands of COVID-19 tests, provided patients and community members with COVID-19 vaccination and treatment, and continue to serve patients by the modalities that best suit their needs. Throughout the pandemic, CHCs partnered with New York City to stand-up high-volume testing and vaccination sites. Some CHCs set up sites at temporary locations within their communities and others did so in their own parking lots.

However, at the height of the pandemic, CHCs' ability to provide access to in person care was limited by the major supply shortages of personal protective equipment (PPE). This exacerbated existing access problems for health center patients - the challenge to source and purchase adequate PPE to conduct in-person services and maintain a stockpile in the event of another surge hindered CHCs' ability to plan for delivery of healthcare services (i.e., in the case of dental services, PPE must be changed between each patient). Inadequate access to PPE also prohibited some health centers from expanding community testing. When considering future emergency response at the city level, it is imperative that CHCs be designated as high priority sites for receipt of PPE.

Looking ahead, challenges persist

A. Workforce shortages are at unprecedented levels

Community health centers re-invest in the communities they serve by hiring individuals who live in the communities they serve. However, CHCs are facing difficulty in maintaining delivery of services due to the COVID-19 pandemic exacerbating existing health care provider shortages. In the summer of 2021, CHCANYS surveyed CHCs on top workforce-related challenges and priorities and CHCs reported immediate staffing needs across occupations including Licensed Clinical Social Workers/Licensed Professional Counselors, Psychiatrists, Nurses, Family Physicians/Internal Medicine, Nurse Practitioners/Physician Assistants, Dental Providers, and Case Managers. CHCs also reported insufficient educational pipelines, uncompetitive wages, and high clinical/case load requirements as some of the reasons for recruitment and retention challenges. Many CHCs are concerned that staffing shortages may cause them to postpone or delay patient care.

To ensure that CHCs can continue to provide quality accessible healthcare services for the underserved communities, there needs to be significant investment in healthcare workforce. Investments could include funding for existing workforce programs, developing new loan repayment programs for nursing and behavioral health staff, especially in communities of color, expanding loan repayment programs for individuals living in medically underserved communities, and increasing workforce development opportunities in medically underserved communities and communities of color.

B. Telehealth must be supported to encourage access to care

Telehealth (audio visual and telephonic) has proven to be crucial to ensuring patients and providers could safely connect amidst an unprecedented health crisis. When NYS issued the stay-at-home order, CHCs quickly pivoted to telehealth to ensure that patients could continue to receive healthcare services. Telehealth enabled CHCs to take care of many patients with coronavirus from home, keeping fewer sick patients out of the overwhelmed hospitals and reducing community spread of the virus. The greatest contribution of telehealth, especially telephonic, is how it has expanded access to healthcare services by decreasing barriers that would usually inhibit the ability to visit a provider, like lack of transportation, childcare issues, or time off from work. According to a recent survey by CHCANYS, CHCs are seeing fewer no shows for remote visits, especially for behavioral health visits, and CHCs predict that about 37% of patients will request remote visits over the next year. Today, about 25% of CHC visits occur via telehealth. For providers, the ability to deliver care through telehealth modalities was a much-welcomed flexibility. CHCs continually report that the ability to offer remote working options to their providers has

increased their ability to recruit new providers who, without that option, would not be interested in working for the CHC.

Currently, and through the duration of the Federal Public Health Emergency (PHE), CHCs are reimbursed for audio-visual telehealth visits on par with face-to-face visits, but at a lower rate for services delivered via the telephone. Telehealth payment parity beyond the pandemic, regardless of modality and regardless of patient and provider location, is needed to ensure that CHCs can continue to provide telehealth services and to recruit new providers.

C. The State's pharmacy benefit carveout proposal will hurt CHCs and their patients

The Federal Public Health Service Act 340B drug discount program was enacted in 1992 by Congress to allow safety net providers, including CHCs, access to pharmaceutical drugs at reduced costs and to reinvest the savings to expand access to health care in medically underserved communities. Community health centers rely on the savings generated through the 340B program to fund life-saving programs and initiatives that have no other funding sources. Many CHCs used 340B savings to conduct vaccine related outreach and patient education, provide, vaccinations to staff of behavioral health organizations, and holding vaccination events in communities of color, often at the request of state and local health departments. Many of the beneficiaries of the 340B program have multiple chronic conditions and other risk factors – those most likely to visit a hospital emergency department or suffer serious complications from COVID-19. However, the 340B program is currently under threat due to the State's proposal to carve the Medicaid pharmacy benefit out of managed care and into fee-for-service, which would result in an annual $61M lost across NYC-based health centers. The pharmacy benefit carveout will not only cause unprecedented disruptions for the safety net community but will also threaten the comprehensive public health response to the COVID-19 pandemic.

In 2021, the NYC Council adopted Res. 1529, calling on the New York State Legislature to pass, and the Governor to sign, S.2520/A.10960, legislation to protect New York State's safety net providers and Special Needs Health Plans by eliminating the Medicaid pharmacy carve-out. Again, we look to the NYC Council to protect community health centers by calling on the State to repeal the pharmacy benefit carve out.

Conclusion

CHCANYS is thankful for the opportunity to submit this testimony to highlight the impacts of COVID-19 on community health centers and the challenges that CHCs continue to face. CHCANYS is hopeful that this is the first of several discussions to mitigate health disparities exacerbated by COVID-19 and advance health equity for all New Yorkers. For questions or follow up, please contact Marie Mongeon, Senior Director of Policy, mmongeon@chcanys.org.

Committee on Health and the Subcommittee on COVID Recovery and Resiliency: Oversight Hearing on COVID-19: Looking Ahead

February 23, 2022

Chair Schulman, Chair Moya, and distinguished members of the City Council, thank you for the opportunity to provide testimony today. I'm Amy Dorin, President & CEO of the Coalition for Behavioral Health. The Coalition represents over 100 community-based mental health and substance use providers, who collectively serve over 500,000 New Yorkers annually

The COVID-19 pandemic significantly worsened New York City's mental health and substance use crisis. Over the past two years, there has been a surge in the demand for behavioral health services. Overdose deaths increased 38% from 2019 to 2020. [i] In just the first quarter of 2021, more New Yorkers died from overdose than in all of 2010.[ii] This catastrophic increase in overdose deaths is just one of the deeply concerning data points that show a crisis.

In 2020, two out of every five New Yorkers reported poor mental health. [iii] Rates of anxiety and depression have drastically increased.[iv] The impact of the pandemic on child and adolescent mental health is particularly concerning. The Surgeon General and American Academy of Pediatrics have both declared a youth mental health crisis.[v] Hospitals and medical centers report dramatic increases in the demand for mental health services. Children's emergency department visits for mental health related concerns increased by 24% for children ages 5-11 and 31% for individuals ages 12-17, from 2019 to 2020.[vi] In the fall of 2020, 55% of NYC youth aged 18 to 24 reported symptoms of anxiety and/or depression.[vii]

It is clear that New Yorkers need more mental health and substance use care. Current resources and programs are simply not sufficient to care for all New Yorkers in need. Before the pandemic, more than one in five New Yorkers who seek behavioral health care are not able to access it.[viii] This number is much higher today.

Unfortunately, our member agencies simply do not have the staff they need to serve these individuals. Longstanding underfunding of mental health programs has created an access to care crisis. The City has consistently failed to provide sufficient investment in its nonprofit mental health and substance use partners. City contracts are paid late. City contracts set salaries for contracted staff that are thousands of dollars lower than what the City pays its own staff in comparable positions. The City has not been a good partner to the community-based mental health and substance use providers it contracts with for these critical services.

Because the City has failed to invest in mental health and substance use services, providers are not able to meet the need in communities. Our member agencies report that programs have staff vacancy rates as high as forty-eight percent. Providers are routinely pausing intakes and opening

waitlists, both unprecedented actions. Behavioral health workers were on the frontlines supporting New Yorkers throughout the pandemic, and setting aside their own grief and trauma to support their clients. Rather than rewarding this service, the City failed to provide even a cost-of-living adjustment in last year's budget.

With a new administration and many new City Council members, the City has an opportunity to change direction and support a holistic recovery from COVID that guarantees New Yorkers will have treatment for their mental health and substance use needs.

Implement Procurement Reforms

The Mayor and Comptroller took a critical first step in resetting the City's relationship with its nonprofit partners by establishing a Joint Task Force on procurement reform. The Coalition strongly supports the recommendations from this taskforce, which will increase prompt payment on contracts, reducing the use of bridge loans and increasing the financial viability of nonprofits. We encourage the Council to look closely at these recommendations and ensure they are implemented quickly and well.

Build the Mental Health & Substance Use Workforce

1) **Fund a 5.4% cost-of-living adjustment** (COLA) on all human services contracts to increase salaries for staff. It is critical that the City match the State's 5.4% COLA. Without this, providers will be placed in an untenable situation of being able to give raises to some staff, who work on state contracts, while keeping salaries flat for staff on city contracts. This will lead to increased turnover and decreased ability to recruit staff on city contracts.
2) **Create, fund and incorporate a comprehensive wage and benefit schedule for contracted mental health workers comparable to the salaries made by City employees.** The City pays social workers, mental health counselors, psychiatrists, psychologists and other mental health professionals a significantly greater amount than the funds it provides for salaries for these same professionals who work for community-based organizations on city contracts. The City must increase funding for salaries and benefits on city contracts to be competitive with city employees.
3) **Build the pipeline of mental health professionals through tuition assistance, loan forgiveness, and internship funding.** The City plays a key role in educating mental health professionals, but the costs for entering this field remain far too high. This is a particular barrier to increasing the diversity of the mental health workforce. It is incredibly difficult for providers to recruit staff who speak languages other than English, because there simply are not enough of these individuals in the behavioral health field. Similarly, Black and brown communities are underrepresented among mental health professionals. To build a more robust and diverse workforce, we recommend the following initiatives:
    a. **Expand the Human Services Career Advancement Scholarship:** this scholarship currently only covers 50% of the cost of tuition, which is simply insufficient. It should cover the full cost of school. The City should also work proactively with service providers to ensure that staff are aware of this opportunity before application deadlines – recently, one of our providers was not informed of the deadline for this program until after the deadline has passed. A scholarship cannot help anyone if staff are not aware of it. Additionally, the

master's degree scholarship should include mental health counseling, which is offered by several CUNY schools.

b. **Provide Loan Forgiveness:** the City should provide direct funding to staff on City contracts who have outstanding student loans. Our workforce often takes on significant student loan debt on the path to becoming a mental health professional, and needs assistance from the City to be able to afford to work in the public mental health system.
c. **Provide Funding for Internships:** a key part of the education of social workers and mental health counselors are supervised internships that occur as part of the master's degree process. These internships are critical to providing students with the first-hand experience they need to become successful clinicians. These internships are not paid, however, and they limit the ability of students to work while going to school, adding yet another financial barrier to this field. The City should provide funding to providers for interns that they host, to pay a robust hourly wage to interns and to cover the agency's supervision costs. A successful internship can be the key to having new graduates enter the public mental health field and work in community-based agencies.

Increase Effective Services for Individuals Experiencing Homelessness and Serious Mental Illness

Recently, there has been significant concern about individuals in NYC who are homeless and have serious mental illness. It is simply not true to broadly state that these individuals are dangerous. This harmful misconception increases stigma without doing anything to help these vulnerable individuals, who are far more likely to be the victims of violent crime than other New Yorkers.

Clearly, these individuals are not currently receiving the mental health services that they need. Much of the current conversation has focused on mandating treatment. However, we would encourage policymakers to focus on the areas where our current system is failing, before moving to expand mandated treatment.

1) **Ensure Hospitals Admit & Discharge Appropriately:** currently, hospitals throughout NYC are not providing sufficient services to individuals with mental illness who are in need of hospitalization. Our member agencies will often bring an individual to an ER or CPEP, having determined, based on their long-standing relationship with the individual and deep knowledge of the individual's condition, that a hospitalization is necessary. In many cases, the individual recognizes the need for hospitalization. However, the hospitals will often simply observe the individual for 1-3 hours and then discharge them. At best, they may admit someone for 24-36 hours, a stay that is too short to truly stabilize the individual. The individual will then be discharged, often without the community provider receiving a notification or any other discharge planning. This does not help individuals with serious mental illness, and it does not help the providers who serve them. In some particularly egregious instances, our members report that hospitals have told them a client is "too dangerous" for an inpatient psychiatric hospitalization. For individuals experiencing acute mental health systems that are causing them to act with violence, it is critical that hospitals have the ability to stabilize these individuals. Community providers cannot offer the intensity of services needed to someone whose illness is at such an acute point. The City must engage with the hospitals, both private and H+H, to improve inpatient psychiatric care and ensure that individuals receive this critical service.

2) **Increase Coordination of Services:** there are many different models now being rolled out to work with street homeless individuals who have mental illness. In addition to the long-standing subway outreach teams, the State is funding Safe Options Support Teams, the City is deploying 30 inter-agency collaborative teams, 12 new DOHMH Neighborhood Response Unit teams, and 12 new cross-agency teams. All of these models may well be good models. However, too many teams operating in this space will simply create confusion and overlap. In addition to these new teams, many of these individuals are already receiving outreach from an ACT or Intensive Mobile Treatment team. It will make it harder for any one time to effectively engage individuals in clinical services and in the move to shelter, safe haven or stabilization beds. There should be careful coordination among these various efforts, clear communication, and uniform access to the databases necessary to do this work.
3) **Streamline the Supportive Housing Placement Process:** we support the Mayor's efforts to streamline the supportive housing placement process. Improving this process will get individuals into supportive housing faster, increasing stability in their lives and ensuring they have access to the wrap-around services they need.

Increase Access to School-Based Mental Health Clinics

COVID has caused a mental health crisis among children. The Surgeon General, American Academy of Pediatrics, the American Academy of Child and Adolescent Psychiatry (AACAP) and Children's Hospital Association have all declared a national emergency in children's mental health. Our providers are seeing this crisis every day, as children enter their programs with more acute illness and more severe needs than pre-COVID. Children need appropriate mental health supports to help them come through the pandemic and go on to lead healthy, happy lives.

School-based mental health clinics provide on-site clinical services. Currently, NYC has 280 school clinics, but these services need more robust funding and should be expanded to serve more schools. Under this model, community providers open a satellite clinic in the school, allowing children to access clinical treatment, including diagnosis, individual and group therapy, family treatment and more. Providers work with school staff to provide trainings on mental health, to institute initiatives to improve school climate and mental wellbeing, and to reduce the use of suspensions, detentions and other punitive measures for children experiencing mental health challenges. Because the provider also has services in the community, the child can continue to receive services as they age and change schools. The provider can also serve the whole family, including children at other schools, as well as parents and caregivers.

This is a critical model for improving children's mental health. Clinics provide high-quality, robust care, with robust supervision of staff and ongoing reviews to ensure the best care. Clinics are able to bill Medicaid and commercial insurance for many of their services, reducing the cost to the City. However, City funding is essential for the full success of this model. City funds go toward serving children who are uninsured, children who do not have a mental health diagnosis, and to providing mental health trainings and services to the broader school population. These dollars are critical to the success of the program.

In the past, the City has failed to coordinate with these providers. Last spring, as children were returning to school with acute mental health needs, the Department of Education (DOE) hired over 125 social workers away from school-based clinics. We cannot improve the mental health

of our children without DOE as a partner at the table. When these staff were moved, children lost access to clinicians they had built trusting relationships with, hampering their care. It took our providers months to fill these positions, delaying care to hundreds of children. As the City looks to improve children's mental health, we hope that community providers will be seen as the critical partners that we are. We encourage the City to expand school-based mental health clinics as a key component of meeting children's mental health needs at this time.

Maintain Mental Health Services for Older Adults

Older adults experienced significant loss and isolation during the COVID pandemic. As the age group most vulnerable to serious illness and deaths, older New Yorkers lost friends, spouses and relatives. They were hospitalized at much higher rates. Many older adults isolated in their homes, and struggled to maintain connections to family and friends through technology that they were not comfortable using. In recognition of this, the City last year expanded funding for the Geriatric Mental Health Initiative, a joint program between the Department for the Aging (DFTA) and OCMH that provides mental health services at senior centers. The expansion was targeted at the neighborhoods hardest hit by COVID. These services have been able to succeed during COVID by pivoting to remote offerings, training clients on how to engage in telehealth, and providing telephonic services.

This program is very successful, serving more than 3,300 older adults in just the past 18 months and providing over 17,000 clinical sessions. Recent data shows clinical improvement rates of 62% for depression and 57% for anxiety after three months of treatment. The program has improved the overall health of older adults and helped keep older New Yorkers in their homes, not in hospitals or nursing homes. It is critical that funding for the expansion to maintained in the FY23 budget. We oppose the cut to the program in the current fiscal year, which will delay the roll-out of these critical services.

The mental health needs of New Yorkers are immense. The City can help New Yorkers access the treatment and services they need through close collaboration with community providers and a significant investment in the mental health workforce. Thank you for the opportunity to testify. We look forward to working with the City Council to ensure robust mental health and substance use services are accessible to all New Yorkers. You can follow-up with me at adorin@coalitionny.org.

---

[i] NYC Department of Health and Mental Hygiene. *Unintentional Drug Poisoning (Overdose) Deaths in New York City in 2020*. November 2021. https://www1.nyc.gov/assets/doh/downloads/pdf/epi/databrief129.pdf.

[ii] NYC Department of Health and Mental Hygiene. *Unintentional Drug Poisoning (Overdose) Deaths Quarter 1, 2021, New York City*. November 2021. https://www1.nyc.gov/assets/doh/downloads/pdf/basas/provisional-overdose-report-first-quarter-2021.pdf.

[iii] New York State Health Foundation. *Mental Health Impact of the Coronavirus Pandemic in New York State*. February 2021. https://nyshealthfoundation.org/wp-content/uploads/2021/02/mental-health-impact-coronavirus-pandemic-new-york-state.pdf

[iv] New York State Health Foundation. *Mental Health Impact of the Coronavirus Pandemic in New York State*. February 2021. https://nyshealthfoundation.org/wp-content/uploads/2021/02/mental-health-impact-coronavirus-pandemic-new-york-state.pdf

[v] Campaign for Health Minds, Healthy Kids (2022, January) *NY Child Mental Health Advocates Applaud Gov Hochul on Commitment to Address Child Mental Health Crisis in SOTS Address.* https://s3.amazonaws.com/media.cccnewyork.org/2022/01/HMHK-SOTS-Statement-Release.pdf

[vi] Leeb RT, Bitsko RH, Radhakrishnan L, Martinez P, Njai R, Holland KM. Mental Health–Related Emergency Department Visits Among Children Aged <18 Years During the COVID-19 Pandemic —

United States, January 1–October 17, 2020. MMWR Morb Mortal Wkly Rep 2020;69:1675–1680. DOI: http://dx.doi.org/10.15585/mmwr.mm6945a3

[vii] Citizen's Committee for Children. *Behavioral Health Supports for Youth Are Essential to New York's Recovery*. (April, 2021) https://cccnewyork.org/behavioral-health-supports-for-youth-are-essential-to-new-yorks-recovery/

[viii] NYS Health Foundation (2021, July). *Still Recovering: Mental Health Impact of COVID-19 Pandemic in New York State.* https://nyshealthfoundation.org/resource/still-recovering-mental-health-impact-of-the-covid-19-pandemic-in-new-york state/?utm_source=Mental+Health+Report+July+2021&utm_medium=email&utm_campaign=Mental+Health+Report+July+2021#anxiety-and-depression-among-new-yorkers-overall

hispanicfederation

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

Testimony re: Oversight - COVID-19: Looking Ahead

Submitted to:
Committee on Health & Subcommittee on COVID Recovery & Resiliency

Submitted by:
Bethsy Morales-Reid, Assistant Vice President of Programs at Hispanic Federation

February 23, 2022

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

COVID-19 Recovery & Resiliency for the Latino Community In NYC

Since the coronavirus pandemic began, Latinx communities have been hit disproportionately hard. Data from the Centers for Disease Control and Prevention (CDC) shows that Hispanics were hospitalized for COVID-19 and dying at disproportionate rates. The pandemic has magnified existing health conditions and the economic impact of COVID-19 has created greater barriers for individuals without health coverage in seeking medical attention. However, this legislative season gives the city an opportunity to fund programs and enact legislation that can enhance health outcomes for underserved communities.

I. Communities of Color Nonprofit Stabilization Fund (CCNSF)

We thank the New York City Council for the $2.5 million in continued support for the Communities of Color Nonprofit Stabilization Fund (CCNSF) in the FY'22 budget. This initiative has grown to serve over 250 community-based organizations across NYC that work directly in communities of color disproportionately affected by the COVID-19 pandemic. Now more than ever, as we continue to struggle through the direct and indirect effects of COVID-19, it is vital that CCNSF receives funding to address the growing needs of our communities. As such, we respectfully ask for your continued support for the CCNSF with a $7 million budget allocation in the FY'23 budget.

Protecting and expanding CCNSF is vital. Our underfunded and over stretched partner organizations are working night and day to provide for communities of color across New York City. Due to overwhelming need, they have been providing services that they were never built to provide. Larger, more-established nonprofits rely on endowments, affluent board leadership, and development teams to provide stability and expansion to their work. Communities of color-led nonprofits do not have access to these types of safeguards and staples due to historical funding inequities. CCNSF funding is crucial in protecting nonprofits and saving critical service providers from succumbing to the economic fallout of the COVID-19 pandemic.

Not only are nonprofits crucial to the social well-being of the city, but we also play a substantial role in the city's economy. Nonprofits alone account for 16% of the private workforce, compared to 10% nationally. The community-based organizations we proudly represent employ thousands of professionals and support staff across our five boroughs: from social workers and immigration lawyers to after-school program staff and health navigators. They serve the most vulnerable populations in our city and keep millions of our residents afloat financially, socially, and mentally.

As nonprofits are feeling the brunt of the harmful economic effects of the COVID-19 pandemic, we are providing services to those most affected by the current health crisis. An allocation of $7 million for New York City's Communities of Color Nonprofit Stabilization Fund is essential to ensure that organizations that are led by and serve people of color survive during the pandemic and beyond.

II. Hunger Relief for Latino Communities

The past two years have created unprecedented challenges for all communities worldwide. In the face of these devastating challenges, the Hispanic Federation has provided an unparalleled response by investing millions in emergency assistance to address inequities in COVID-19 response amongst the Latino immigrant community. Our COVID-19 Relief Fund has committed over $8.1 million dollars to provide vital food, health, housing, immigration, and employment services supporting 300 frontline Latino, Black, and immigrant-led organizations. These efforts have also provided direct relief to support struggling families and 711 small businesses with grants totaling $5.1 million dollars in addition to committing another $2.5 million dollars to address the growing concerns of food insecurity in communities of color by restocking food pantries.

HF's long-running *Lucha Contra El Hambre* hunger relief initiative provides food to pantries operated by HF member agencies and partners. In response to the exponential increase in food insecurity experienced by Latinos in New York City neighborhoods hardest hit by the coronavirus pandemic, and because of HF's expanded hunger relief efforts, HF received $1 million from the New York City Department of Youth and Community Development (NYC DYCD) last year to provide culturally competent food assistance to needy Latino families in partnership with our network of Latino community-based organizations in all five boroughs. Pantries run by our members have multiplied their operations to meet the increased demand from their communities. Some sites have grown to become food hubs, distributing food to smaller operations and tenant groups providing mutual aid to their neighbors unable to access food support otherwise. In addition to supporting our hunger relief partners in meeting their increased demand, we have been able to support new partners fighting hunger. In some cases, these new partner organizations did not provide hunger relief prior to the pandemic but had to pivot their programming and services to meet the rise of food insecurity among their constituents and also the needs of new clients seeking help. We also purchased cooked meals prepared by local restaurants for distribution through local nonprofit partners in efforts to support small businesses while providing culturally appropriate foods for low-income Latino families. As a result of this boost, over 92,000 Latino New Yorkers in need have been served, close to 300,000 meals via our expanded hunger relief efforts distributed by our network of member and partner agency pantries and our local restaurant hot meals initiative. We request $150,000 for this vital program.

III. Continued Culturally Relevant COVID-19 Vaccine Information

Two years after the onslaught of the pandemic, the need for COVID-19 vaccine outreach and education for communities of color remains. Although Latino numbers have gone down significantly in certain age categories, they still have the highest proportional COVID related death rates of any group in the U.S. in every single one of the age categories. However, we know that our efforts are being effective. Vaccine outreach and education by trusted messengers within the community are working. The Center for Disease Control and various efforts across the country have made it clear that the impact of trusted messengers in local communities are the engine for recovery, as their message is the most effective with community members.

From August to December 2021, HF has successfully launched a media campaign that has made nearly 20 million impressions via social, digital, tv, and radio media. We've held over 1,300 events across the state, engaged with nearly 1.2 million New Yorkers, and vaccinated over 10,300 individuals. Hispanic Federation has funded 36 organizations under this initiative and these agencies are working effectively and diligently. We must have the resources necessary to continue these extremely successful efforts, especially as children – toddlers and infants – become eligible for the vaccine. Our subgrantees cover all of New York City and upstate New York and are undertaking monumental efforts to provide linguistically and culturally relevant vaccine information to the community.

Through generous state funding, HF has been able to strategically support various nonprofit community health and human service organizations to continue increasing Latino vaccination rates across New York City and in the state by implementing:

- **COVID Vaccine Education and Awareness:** Carrying out mass and micro-targeted public education efforts to dispel fears and misconceptions about the virus and inform vulnerable and eligible Latino residents where they can get tested locally, especially considering newly eligible age groups (children, toddlers, and infants expected in 2022).
- **COVID Vaccination Case Management:** Providing active case management for vulnerable, at-risk and priority Latino residents who require help in getting vaccine information, immunization enrollment, and a continuum of care.
- **Establishment of COVID-19 Community Vaccination and Education Sites:** Activating and preparing local hubs/sites to serve as community vaccination centers for Latinos. In addition to conducting ongoing vaccination drives, grantees under this category will be required to conduct mass and micro-targeted vaccine education and awareness efforts.

IV. Overall Recovery for Latinos in NYC

Latinos have significant risk factors that heightened their rates of infection, hospitalization, and deaths. One risk factor is diabetes, which Latinos experience disproportionately and has been linked to worse COVID-19 outcomes. As the city continues vaccination efforts, the mistrust and hesitancy of many Latinos must be addressed through meaningful funding and programming. The NYC Vaccine for All Campaign has been a great push to broadcast the effectiveness and safety of the vaccines as well as website scheduling

in a language our community can understand. Cultural competency is crucial when implementing programs for the Latino community. NYC must continue to fund this important program.

The pandemic has expanded the use of telemedicine and highlighted this as the way of the future. This raises concerns with the digital divide, particularly for seniors and Latinos' ability to access care and information equitably. The City Council must invest in efforts to bridge this gap by funding digital literacy programs. This gap affects not only access to healthcare, but access to education, benefits, and services. Additionally, mental health has become a large concern due to the pandemic. We're grateful to the city's commitment to funding the Immigrant Health Initiative at $2 million in previous years and the inclusion of mental health services in this program. Now more than ever, investments in overall health services for immigrants is crucial. This fiscal year, the City Council should increase this program's funding to address the growing health disparities among immigrants resulting from the pandemic and to provide health care in a culturally sensitive and linguistically relevant manner.

To equitably address the health of Latinos in our city, we must address the social determinants of health and recognize that the foods people eat, where they live, and where government resources are directed have a profound effect on an individual's health. Prioritizing preventative health care will create a robust public health plan for New York's diverse Latino community. Rebuilding the health of our neighborhoods post-pandemic must address the varying factors that lead to underlying health conditions and historic disparities. By funding preventative health services, the Council signals that the health and wellness of Latino New Yorkers equates to a healthy and vibrant New York.

I thank you for your time and reemphasize how critical it is to focus on these priorities for the health of our communities and, in turn, the entire city.

Testimony Submitted By:

Sara Abiola, PhD, JD, Executive Director
Laurie M. Tisch Center for Food, Education & Policy
Teachers College, Columbia University

&

Lesley Kroupa, JD, MS, RD, Interim Deputy Director
Laurie M. Tisch Center for Food, Education & Policy
Teachers College, Columbia University

Oversight Hearing: COVID-19: Looking Ahead
Subcommittee on COVID Recovery and Resiliency and Committee on Health
February 23, 2022

The Laurie M. Tisch Center for Food, Education & Policy at Teachers College, Columbia University (the "Tisch Food Center") conducts and fosters research about the connection between a just and sustainable food system and healthy eating and translates it into recommendations and resources for educators, policy makers, and community advocates. We have more than twenty years of experience working in NYC public schools, collaborating with countless educators, parents, students, food service professionals, and school wellness programs. In September 2019, the Tisch Food Center established the Food Ed Hub through a contract with the New York City Council. The Food Ed Hub fosters collaboration and coordination among school-based food and nutrition education organizations to align resources, increase efficiency, and identify best practices that can be brought to scale. Within the Food Ed Hub, we launched the Food Ed Coalition, a diverse group of over 300 food and nutrition education advocates, program leaders, and school community members.

Much of our work[1] over the past two years has focused on public institutions' response to the COVID-19 food and nutrition security crises. We appreciate the opportunity to share a specific food policy recommendation for the City Council to consider as we look ahead to protect the health of all New York City residents.

Int 1326B ("The Sweet Truth Act"): Amendment needed to expand coverage

Before facing the acute public health challenges of the COVID-19 pandemic, New York City residents faced – and continue to face – an epidemic of diet-related chronic diseases, such as heart disease, type 2 diabetes, obesity, and certain cancers. An estimated **987,000[2] NYC residents have type 2 diabetes** and more than half[3] of adult New Yorkers have overweight or obesity. Almost half of elementary school children in NYC do not have a healthy weight, which puts them at increased risk of metabolic syndrome, type 2 diabetes, and cardiovascular disease.[4]

---

[1] New York Food 20/20: Vision, Research, and Recommendations During COVID-19 and Beyond. The Hunter College NYC Food Policy Center; The Laurie M. Tisch Center for Food, Education & Policy, Teachers College, Columbia University; and, The CUNY Urban Food Policy Institute. September 2020. https://www.tc.columbia.edu/tisch/research/news/new-york-food-2020/
[2] Type 2 Diabetes. New York City Department of Health and Mental Hygiene. https://www1.nyc.gov/site/doh/health/health-topics/diabetes.page
[3] Obesity. New York City Department of Health and Mental Hygiene. https://www1.nyc.gov/site/doh/health/health-topics/obesity.page
[4] Obesity. Columbia Center for Children's Environmental Health. Updated January 24, 2022. https://www.publichealth.columbia.edu/research/columbia-center-childrens-environmental-health/obesity

The COVID-19 pandemic exacerbated these conditions,[5] typically due to a variety of factors like physical inactivity, stress, and limited access to healthy food options. Moreover, when New York City was the U.S. epicenter of the pandemic in the spring of 2020, **New York City experienced the largest increase of any urban area in the U.S. in nonrespiratory deaths, due to heart disease (398%) and diabetes (356%)**.[6]

The Sweet Truth Act - passed on December 15, 2021- is an important step in combating the epidemic of type 2 diabetes in New York City. It is a bipartisan bill that was sponsored by then Councilmember Mark Levine and endorsed by Mayor Eric Adams that requires **warnings on prepackaged chain restaurant menu items that contain more than a day's worth of added sugars** (50 grams based on an average 2,000 calories per day diet). The Sweet Truth Act is the first of its kind in the United States.

However, opponents of the law succeeded in narrowly tailoring the law to only cover prepackaged foods and drinks. **This is an irrational, arbitrary, and confusing carve-out in the law**. When a customer walks into a fast-food restaurant and is standing in front of a fountain soda machine next to a refrigerated case of bottled sodas, the bottled sodas will contain a warning label, but the fountain sodas will not. This could lead customers to mistakenly believe that the fountain soda may contain less sugar than the bottled. This could not be further from the truth. **A recent study[7] by the Center for Science in the Public Interest found that most medium-size fountain colas pack in more than 1.5 days' worth of added sugars. A large fountain cola? Two days' worth.** Egregious amounts of added sugars have become the default for many chain restaurant items and the public deserves transparency when making choices for themselves and their families.

It also important to note that New York City has over two thousand chain restaurants,[8] many of which are concentrated in Black and Latino neighborhoods. It is an issue of public health and equity to ensure that every consumer is empowered to make informed decisions about the food that they put in their bodies to protect their own health and the health of their kids.

The law must be revised to include **all** food and drinks in chain restaurants, especially fountain sodas. Both the New York City Council and Mayor Adams have the authority to extend the policy to fountain drinks and other items prepared in-store, which would give New Yorkers the whole truth about the added sugars in chain restaurant meals.

For more information, please contact:

Sara Abiola, PhD, JD
Executive Director
Laurie M. Tisch Center for Food, Education & Policy
Teachers College, Columbia University
Sa3049@tc.columbia.edu

[5] Noguchi Y. Obesity Rates Rise During Pandemic, Fueled by Stress, Job Loss, Sedentary Lifestyle. NPR. September 29, 2021. https://www.npr.org/sections/health-shots/2021/09/29/1041515129/obesity-rates-rise-during-pandemic-fueled-by-stress-job-loss-sedentary-lifestyle

[6] Woolf SH, Chapman DA, Sabo RT, Weinberger DM, Hill L. Excess Deaths From COVID-19 and Other Causes, March-April 2020. JAMA. 2020;324(5):510–513. doi:10.1001/jama.2020.11787

[7] Center for Science in the Public Interest. Sweet Excess: Largest Restaurant Chains Consistently Serve Up Drinks with More Than a Day's Worth of Added Sugars. July 2021. https://www.cspinet.org/sites/default/files/attachment/Soda%20Sizes%20Fact%20Sheet_FINAL.pdf

[8] Torres M, Shaviro C, Dvorkin E. State of the Chains, 2020. Center for Urban Future. December 2020. https://nycfuture.org/pdf/CUF_StateoftheChains_2020_final.pdf

PRIMARY CARE DEVELOPMENT CORPORATION

Primary Care Development Corporation Testimony
New York City Council Joint Health Committee
Oversight-COVID 19 Hearing
February 23, 2022

Thank you to Chair Schulman and Chair Moya, and to the committee for the opportunity to provide testimony today. Primary Care Development Corporation (PCDC) is a nonprofit organization and U.S. Treasury-certified community development financial institution located in New York City.

PCDC's mission is to create healthier and more equitable communities by building, expanding, and strengthening access to quality primary care through capital investment and practice transformation, as well as policy and advocacy. Since our founding in New York City in 1993, PCDC has leveraged more than $1.3 billion to finance over 207 primary care projects. Across the country, these strategic community investments have built the capacity to provide 4.4 million medical visits annually, created or preserved more than 18,585 jobs in low-income communities, and transformed 2.5 million square feet of space into fully functioning primary care and integrated behavioral health practices. In New York State specifically, we have worked with health care organizations, systems, and providers across the state on over 3,200 financing and technical assistance projects to build, strengthen, and expand primary care operations and services.

I. The Critical Relationship Between Primary Care Access and the Impact of COVID-19

Primary care saves lives, improves individual and community health, and is central to health equity.[i] In fact, primary care is the only part of the health system that has been proven to lengthen lives, reduce health disparities, and reduce costs. However, primary care remains overburdened and underinvested; the role of primary care in public health planning and emergency preparedness has been undervalued; and the failure to prioritize primary care in this crisis has been felt most acutely by marginalized communities.

With much appreciated support from this Council, PCDC undertook research to identify the relationship between access to primary care and the impact of COVID-19. Unfortunately but unsurprisingly, our research revealed that communities with less access to primary care before the pandemic experienced more COVID infections and COVID-related illness and deaths than communities with better access to primary care.[ii] Our report on this research, *Primary Care Access and Equity in New York's City Council Districts*, was initially released in July of last year, but we will be re-presenting the data again in a webinar on March 7th so that Council members and staff have an opportunity to hear the details and ask any questions.

Councilmembers, staff and members of the public can register at https://pcdc.zoom.us/webinar/register/WN_GhhXIs1kQPmnIDgkGP78yw. We also encourage members of the Council to reach out at any time for more information about primary care in New York City and in their districts.

As a result of the pandemic, we have also seen the deferral of necessary health care, which is leading to a crisis of its own. People are now coming back to primary care with more severe preventable diseases, including more advanced cancers, and a drop in childhood vaccinations that could impact children and communities for decades to come.[iii] These lapses might have been prevented if primary care had been included in the initial COVID-19 response.

II. The Role of Primary Care in Pandemic Planning and Preparedness

As we continue to navigate the COVID-19 pandemic, New York City must think critically about the role of primary care in its resiliency efforts, planning for future public health crises, and accelerating efforts to address the disparities that have been so starkly illuminated. Primary care not only keeps people healthy and protected against severe disease and reduces health disparities,[iv] but "the primary care sector has an essential role in public health emergency preparedness" [v] as well.

Primary care's role in preparing for and mitigating public health emergencies is not a new phenomenon. Yet despite expert research and previous experience, the primary care sector was largely left out of early COVID-19 planning, service delivery, and mitigation efforts. Eventually, Federally Qualified Health Centers (FQHC) were included the federal vaccine distribution plan, and PCDC was grateful to be able to play a role in ramping up FQHC vaccine distribution in New York City. We worked with the CDC and New York City Department of Health and Mental Hygiene (DOHMH) to survey FQHCs about their planning effort, and then distribute $6 million of federal grant money to help those that were interested with vaccine planning and preparedness. More recently, with improvements in vaccine availability, other types of PCPs have begun to deliver COVID vaccinations at a time when they are also addressing the twin crises of deferred care and worsening health and mental health issues.

PCDC encourages the Council to support a thorough review of primary care providers' experience in this pandemic, including not just health centers but also independent primary care practices and hospital-associated primary and ambulatory care facilities. This research could focus on the guidance primary care givers were provided with, if any, as well as access to PPE, emergency funds, testing materials, and finally, vaccines, so that we can learn from this pandemic, plan more effectively, and include all types of primary care providers from the beginning in the next pandemic or emergency.

Much is already known about primary care providers' role in a pandemic. More than a decade ago, during the height of the H1N1 pandemic, PCDC and the Community Health Care Association of New York State (CHCANYS), working with DOHMH and New York City Emergency Management, developed the Primary Care Emergency Preparedness Network (PCEPN) in New York City. PCEPN's mission was to improve the ability of New York City's primary care sector to prepare for, respond to, and recover from health care crises, as well as to bring primary care representation to city government's emergency planning process.[vi] In 2015, a study in the *American Journal of Public Health* evaluated the impact of PCEPN and found that:

> The primary care sector has an essential role in public health emergency preparedness. Facilities providing primary care can directly augment and support crises medical surges because they routinely deliver clinical care for a large segment of the population across a broad spectrum of medical services. Primary care facilities and practitioners can also provide adequate medical evaluation and care during large-scale events that exceed the limits of the typical emergency medical infrastructure in an affected community.[vii]

The study concluded that primary care providers who participated in the program, which included training and coordination with city officials and emergency planners, were more prepared to respond during a pandemic or other health crisis. The study also concluded that while "[p]artnership between public health and primary care is essential for effectively responding to and recovering from public health threats. . . [p]rimary care faces many challenges in preparing for emergencies including lack of resources and lack of communication with external stakeholders, such as public health agencies."[viii]

Unfortunately, the lessons learned from this program and report were not implemented or even recognized as policymakers confronted the COVID-19 pandemic. A 2020 report from the Council on Foreign Relations aptly described the role of primary care in a pandemic and the responsibility of policymakers to understand and support it, echoing the 2015 *American Journal of Public Health* findings:

> Primary care systems help nations respond to pandemics in multiple ways. They provide a ready infrastructure for disease surveillance. They promote healthier populations by preventing and managing chronic illnesses that often worsen health outcomes from emerging infections. They nurture trust, cultivated in strong patient-provider relationships, which reduces the harm of medical misinformation and disinformation campaigns. Finally, they can bolster surge capacity during pandemics, particularly when patient volume spikes in emergency care settings. These multiple benefits suggest that greater investments in primary care should be

> a central element of any effort to strengthen the pandemic response capacity of the U.S. health-care system.[ix]

Yet, policymakers failed to support or utilize primary care providers as key actors when the COVID-19 pandemic began. The Council on Foreign Relations notes that early on, "patients seeking medical attention for COVID-19 overwhelmed emergency rooms and urgent clinics," which should have resulted in additional support and funding directed to helping patients see primary care providers whenever possible to keep emergency rooms for those who were in critical condition. Instead, "funding and logistical support for family medicine, trauma surgery, pediatrics, and obstetrics and gynecology has remained stagnant,"[x] and for those providers dependent on "fee-for-service" visits, the deep decline in in-person visits made it nearly impossible for many primary care providers to maintain their services, especially before the relaxing of the telehealth regulatory framework.[xi]

The American Academy of Family Physicians (AAFP) has reached similar conclusions, noting to Congress in a June 2020 letter that "the most significant barrier to health system resilience is the lack of a long-term, objective and consistent support necessary for public health and primary care . . . any effort to prepare for future pandemic must include a clearly defined primary care strategy."[xii] Moreover, AAFP noted that COVID-19, like many other respiratory illnesses, is most likely to be diagnosed by a primary care provider – data from 2018 indicate that while 260,000 patients are hospitalized with respiratory infections each year, 19.5 million patients with respiratory conditions are seen annually by primary care providers.[xiii]

III. Conclusion

In the past year, PCDC has published research showing that: (1) the impact of COVID-19 fell hardest in New York City on communities that lacked access to primary care before the pandemic;[xiv] (2) that delays in accessing health care were associated with worse COVID-19 outcomes across the state; and (3) that communities in New York with more FQHCs had reduced COVID-19 mortality.[xv] Our research further drives home the point that without primary care access, communities will have worse health outcomes, both from COVID and other preventable diseases – in contrast, *with* access to quality primary care, communities are better protected both from COVID and many other health issues.

It is critical that primary care be included in pandemic planning and preparedness. We urge the Council to determine the gaps that existed in this pandemic and support efforts to include all types of primary care providers from the beginning in the next public health emergency. We welcome the opportunity to work with the Health Committee and the New York City Council to expand access to primary care for all New Yorkers, particularly for those in disinvested,

underserved communities. Please contact Jordan Goldberg, Director of Policy, at jgoldberg@pcdc.org with any questions or to request additional information.

Thank you for your consideration of PCDC's recommendations.

---

[i] Barbara Starfield, *Primary Care And Equity In Health: The Importance To Effectiveness And Equity Of Responsiveness To Peoples' Needs*, 33 Humanity & Society 56 (2009), *available at* https://www.jhsph.edu/research/centers-and-institutes/johns-hopkins-primary-care-policy-center/Publications_PDFs/A243.pdf; James Macinko, Barbara Starfield, Leiyu Shi, *Quantifying the Health Benefits of Primary Care Physician Supply in the United States*, 37 Int. J. of Health Serv. 111 (2007), *available at* https://www.researchgate.net/publication/6391542_Quantifying_the_Health_Benefits_of_Primary_Care_Physician_Supply_in_the_United_States; Leiyu Shi et al., Primary Care, *Self-rated Health, and Reductions in Social Disparities in Health*, 37 Health Serv. Res. 529 (2002), *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1434650/; Lynn A Blewett, et al., *When a usual source of care and usual provider matter: adult prevention and screening*, 23 J. Gen. Intern. Med. 1354 (2008), *available at* https://pubmed.ncbi.nlm.nih.gov/18506542/.

[ii] *See, e.g.* Primary Care Development Corporation, *Primary Care Access and Equity in New York's City Council Districts*, July 2021, *available for download at* https://www.pcdc.org/resources/nyc-council-district-primary-care-access-and-equity-report/.

[iii] Dave A. Chokshi & Mitchell H. Katz, *Emerging Lessons From COVID-19 Response in New York City*, JAMA Forum, April 20, 2020, *available at* https://jamanetwork.com/journals/jama-health-forum/fullarticle/2764817.

[iv] Barbara Starfield, *Primary Care And Equity In Health: The Importance To Effectiveness And Equity Of Responsiveness To Peoples' Needs*, 33 Humanity & Society 56 (2009), *available at* https://www.jhsph.edu/research/centers-and-institutes/johns-hopkins-primary-care-policy-center/Publications_PDFs/A243.pdf; James Macinko, Barbara Starfield & Leiyu Shi, *supra note* 54; Leiyu Shi, Barbara Starfield, Robert Politzer et al., *supra note* 5; Lynn A Blewett, et al., *When a usual source of care and usual provider matter: adult prevention and screening*, 23 J. Gen. Intern. Med. 1354 (2008), *available at* https://pubmed.ncbi.nlm.nih.gov/18506542/.

[v] Marsha D. Williams et al., *Primary Care Emergency Preparedness Network, New York City, 2015: Comparison of Member and Nonmember Sites*, 107 Am. J. Pub. Health. S193 (2017), *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5594394/. *See also Primary Care in the COVID-19 Pandemic: Improving access to high-quality primary care, accelerating transitions to alternative forms of care delivery, and addressing health disparities*, Center for Primary Care, Millbank Memorial Fund & Care Quest Institute for Oral Health, (Sanjay Basu et al., eds. April 2021) *available at* https://www.milbank.org/wp-content/uploads/2021/04/Book_Primary_Care_During_COVID_ebook_4-27-21.pdf.

[vi] Marsha D. Williams et al., *Primary Care Emergency Preparedness Network, New York City, 2015: Comparison of Member and Nonmember Sites*, 107 Am. J. Pub. Health. S193 (2017), *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5594394/.

[vii] *Id.*

[viii] *Id.*

[ix] Thomas J. Bollyky & Stewart M. Patrick, *Independent Task Force Report No. 78: Improving Pandemic Preparedness: Lessons From COVID-19, Council on Foreign Relations*, October 2020, https://www.cfr.org/report/pandemic-preparedness-lessons-COVID-19/recommendations/ (last visited December 9, 2021).

[x] *Id.*

[xi] Corrine Lewis et al., *Primary Care and the COVID-19 Pandemic*, The Commonwealth Fund, April 22, 2020, https://www.commonwealthfund.org/blog/2020/primary-care-and-covid-19-pandemicCommonwealth fund (last visited December 12, 2021).

[xii] Press Release, *Health System Preparedness, Resilience Depend on PC, Says AAFP*, American Academy of Family Physicians, July 14, 2020, *available at* https://www.aafp.org/news/government-medicine/20200714hhs-senateletters.html.

[xiii] *Id.*

PRIMARY CARE DEVELOPMENT CORPORATION

[xiv] Primary Care Development Corporation, *Primary Care Access and Equity in New York's City Council Districts*, July 2021, *available for download at* https://www.pcdc.org/resources/nyc-council-district-primary-care-access-and-equity-report/.

[xv] Primary Care Development Corporation, *Points on Care: Poor Access To Care Drives Covid-19 Outcomes In New York: Federally-Qualified Health Centers help reduce community-level COVID-19 mortality*, April 2021, *available at* https://www.pcdc.org/wp-content/uploads/Points-on-Care-_-Issue-7-_-NY-FQHC-Access-and-COVID-19.pdf

TRINITY CHURCH
WALL STREET

02.23.22 - Trinity Testimony - Committee on Health (jointly with the Subcommittee on COVID Recovery and Resiliency)

February 23, 2022 | **Subject**: COVID-19 - Looking Ahead

Dear Chair Schulman, Chair Moya, and Members of the Committee on Health and the Subcommittee on COVID Recovery and Resiliency,

My name is Natasha Lifton, and I am the Director of Government Relations at Trinity Church Wall Street. Thank you for providing Trinity Church with the opportunity to submit testimony on the City's public health response to COVID-19 moving forward. Our testimony focuses on the impact of COVID-19 on justice-involved New Yorkers and the steps the Department of Correction and the City's leadership should take to protect the health and well-being of those detained and those who work throughout its jails.

As many of you know, Trinity Church Wall Street is an Episcopal Church down the street from City Hall with a congregation of more than 1,600 parishioners, who represent all five boroughs and form an ethnically, racially, and economically diverse congregation. In addition to our parish ministry, Trinity Church carries out our mission of faith and social justice by providing direct services, operating a grant-making program, and engaging in advocacy at the City and State level to advance racial justice and break the cycles of mass incarceration, mass homelessness, and housing instability across New York City.

As part of our mission, Trinity Church partnered with several other faith leaders in 2020 to launch the Faith Communities for Just Reentry Campaign (FCJR). The campaign is a coalition of over 40 faith leaders from all five boroughs that seeks to address the urgent needs of our fellow New Yorkers leaving City jails and improve the City's reentry system by advocating for policies informed by the experiences of justice-involved individuals and our grantees who provide critical services to them.

As faith leaders and fellow New Yorkers, we have been deeply concerned by the humanitarian crisis on Rikers Island amid the COVID-19 pandemic and the life-threatening impact that the virus has had on the health and well-being of New Yorkers detained in and who work at City jails. Since COVID was first detected in New York in March of 2020, New York City's jails have become hotspots for COVID-19 transmission as the Department of Correction neglected to take the necessary precautions.

TRINITY CHURCH
WALL STREET

Over the past two years, numerous reports have uncovered how the City failed to provide sufficient PPE to justice-involved individuals and did not implement proper social distancing measures within these crowded congregate settings to prevent the spread of COVID-19. As a result, the City's jails have seen higher rates of COVID-19 transmission than the general public throughout the pandemic, especially amid the surge of cases caused by the Delta and Omicron variants. Additionally, only 38 percent of all justice-involved individuals detained throughout New York City's jails have been fully vaccinated as of December 2021, which further increases the chances for incarcerated individuals to suffer from severe health complications caused by contracting COVID-19. It also means that those who work in the jails are at greater risk of contracting the virus and bringing it home to their families and communities.

This situation is unacceptable. It fails to uphold the dignity and humanity of those detained, as well as those who work with them. We urge our leaders to implement evidence-based decarceration strategies that will safely reduce the City's jail population and move forward on the plan to close Rikers Island by 2026 and create a new and equitable network of jails.

In addition, we believe that the Mayor and the City Council can take meaningful steps in the short term to protect the health and safety of all New Yorkers either currently detained or being released from jail as the City plans its continued public health response to COVID-19.

First, we know that vaccines are the surest path to ensuring immunity from infection or, a good outcome should the virus break through. The City *must* provide every justice-involved individual with peer- and expert-informed education and access to the COVID-19 vaccine while they are detained. Similar to other carceral settings across New York and throughout the United States, New York City's jails continue to see disproportionately low COVID-19 vaccination rates among justice-involved individuals primarily due to historic and legitimate distrust between those in jail and their in-custody medical providers. We recommend that the City expand its partnerships with trusted external entities, such as community-based health care providers that use a peer model and allow them to provide comprehensive public health programming on the COVID-19 vaccine in its jails. This would be a critical tool to boost the vaccination rate within our jails, as well as make New York City more resilient to future waves of COVID-19 cases.

TRINITY CHURCH
WALL STREET

Second, the City should provide every justice-involved individual with access to COVID-19 testing both when they are detained and immediately prior to release from jail. In light of the disproportionately high rates of COVID-19 transmission in City jails, especially amid the past surge in cases caused by the COVID-19 variants, it is imperative that testing be included as part of the discharge process. Failure to provide such testing increases the chance that the virus spreads from a high infection setting into the communities most likely to receive those returning home.

Thank you for providing Trinity Church Wall Street the opportunity to submit testimony.

Good Morning, my name is Sara Bond. I'm a Brooklyn resident and graduate student at the NYU School of Global Public Health.

I am so proud to complete my public health training in New York City because the policies passed here set the precedent for the rest of the United States. Our city built a legacy with our responses to HIV/AIDS and tobacco - truly groundbreaking initiatives that are now in public health textbooks across the country! As we look ahead at COVID-19 recovery, I have a specific ask for you to continue that legacy with another policy that would be the first of its kind in the nation and improve our health. I urge you to extend the Sweet Truth Act to cover all menu items, not just prepackaged foods.

I've learned in my studies that sugar-sweetened beverages are the primary source of added sugar in America, which directly contributes to nutrition-related diseases. Dr. Chokshi spoke directly about upstream factors - If we want to improve nutrition status, it seems like fountain sodas are a low-hanging fruit because most fountain sodas exceed the daily limit of added sugar, even in "small" sizes. Studies show that most consumers underestimate the sugar in beverages by up to 46% and given the impact of added sugar consumption on diabetes risk we just can't afford that.

For example, the state spends an additional $15,366 per diabetic Medicaid patient per year than it does on non-diabetic recipients. Excess diabetes costs have reached $13.4 billion per year, which nudged total Medicaid costs to $74.5 billion per year. By contrast, the New York State education budget is $37.8 billion per year.

And from a health equity standpoint, SSB consumption is higher among Black and Latinx populations, disproportionately exposing them to chronic diseases and COVID-19 complications that perpetuate historic health disparities. Black, Latinx, and Asian New Yorkers are at least **twice as likely** to have diabetes as whites residents, even when you control for the social determinants of health like socioeconomic status as mentioned by Drs Chokshi and Vasan. Failure to offer honest information about the ingredients in foods hyper-marketed to these groups is an acute failure to them, and to be honest, to echo Councilmember Barron's earlier sentiments, are not aligned with a commitment to addressing systemic racism.

I love being a New Yorker. But the continued success of our city rides on our ability to reach our full health potential - as individuals and communities. Protecting citizens' health is what truly gives them the choices and opportunities that New York City is known for.

Thank you for allowing me to speak to you about what I consider one of the most critical issues of our lifetime - during a pivotal moment in our city's history.