CITY COUNCIL
CITY OF NEW YORK

---------- X

TRANSCRIPT OF THE MINUTES

Of the

COMMITTEE ON HOSPITALS

---------- X

MARCH 1, 2021
Start: 10:10 A.M.
Recess: 12:45 P.M.

HELD AT: REMOTE HEARING VIRTUAL ROOM 3

B E F O R E: CHAIR CARLINA RIVERA

COUNCIL MEMBERS: FRANCISCO MOYA
ALAN N. MAISEL
STEPHEN T. LEVIN
CARLOS MENCHACA
DIANA AYALA
ANTONIO REYNOSO

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

MATILDE ROMAN
MARGARITA LARIOS
LLOYD BISHOP
SARA KIM
HALLIE YEE
LORI HUANG
SABA NASEEM
ERICK AGARIJO
REHAN MEHMOOD
MON YUCK YU
ANTHONY FELICIANO
ANDY OSPINA

STG. KOTOWSKI: The computer record is started. Can we start the Cloud, please?

STG. PEREZ: Backup is rolling.

STG. KOTOWSKI: Great. Sergeant Hope, could you give us the opening, please?

STG. HOPE: Sure. Thank you. Good morning, and welcome to today's remote Council hearing on the Committee on Hospitals. At this time, will all Council Members and Council Member staff please turn on your videos. I repeat, at this time, will Council Member and Council Member staff please turn on your videos. Thank you. To minimize disruption, please place all electronic devices to vibrate or silent mode. If you wish to submit testimony, you may do so at council.nyc.gov. I repeat, testimony@counil.nyc.gov. Chair, we are ready to begin.

CHAIR RIVERA: Good morning everyone. I am Council Member Carlina Rivera, Chair of the Committee on Hospitals and I want to start by thanking everyone present today and all the staff who allowed this meeting to happen procedurally. So, I'd

like to acknowledge that we've been joined by some of my colleagues. I saw Council Member Moya, Council Member Maisel, Council Member Levin, Council Member Menchaca, and I'm sure we will be joined by other Council Members throughout the hearing. So, good morning again everyone. I am Council Member Carlina Rivera, Chair of the Committee on Hospitals, and I want to start by thanking everyone present today. Insuring access to equitable care is topic I care deeply about, and that necessarily includes insuring language access and cultural humility and competency within our New York City hospitals during the COVID-19 pandemic and beyond. Many of us have stories, and even more of us now have stories because of COVID-19. Stories of loved ones being deprived of care because they cannot adequately express their concerns in their preferred language. Stories of being expected to be our families' interpreters, or stories of individuals faced with a medical community that has a general lack of understanding of stigma and nuance within our cultures and identities. So, I want to share a person story with this struggle that clearly shows how the city's failure to fund community organizations, conduct door-to-door outreach, and

offer reasonable accommodations at hospitals as well as testing and vaccine sites are directly affecting New Yorkers during this pandemic. My uncle, a disabled, elderly man with underlying chronic conditions who lives alone in Williamsburg, Brooklyn has been struggling to secure a vaccine. He speaks and sings beautifully in Spanish only, and being blind, he unfortunately never had the resources to learn Braille. His dedicated home attendant of many years has COVID, but at 82, he cannot wait any longer to schedule his appointment. What he managed to do was memorize the vaccine hotline number and call over and over and over again until he got an appointment for March 10th at Woodhull Hospital. Thankfully, yes, he now has an appointment, but his home health aide may not be available to take him. Now, my family can help him, but the city should not be relying on friends and families and communities to assist our hard-to-reach New Yorkers, and obviously, this isn't just a vaccine related issue. We're here today to examine how all care in hospitals is made worse without effect language access and cultural humility. New York City is unlike any other with incredible diversity. New Yorkers speak over 200

languages. In addition, about a quarter of New Yorkers identify as a limited English proficient, or LEP, and about half of all immigrant New Yorkers identify as LEP. We know that the inability to communicate proficiently in English can pose incredible barriers for LEP individuals when it comes to accessing healthcare. For example, we know that patients who identify as LEP experience adverse health outcomes at markedly higher rates than English speakers. They experience high rates of medical errors, have worse clinical outcomes and receive lower quality of care by other metrics than their English-speaking counterparts. Also, language barriers are associated with prolonged hospital stays, medication errors, and other disasters that are costly for patient. Unfortunately, the COVID-19 pandemic has only magnified the gaps faced by those who are LEP and multiple the logistical barriers for medical interpretation. Especially at the height of the pandemic. Healthcare workers have stated that amidst the over-burdened, chaotic, and crowded hospitals in the city, patient likely would have received better care if they spoke English. Interpretation is all remote, and with medical staff

masked, their voices muffled, and COVID cases often evolving at rapid rates, there are numerous obstacles to effective interpretation. Patients who are LEP are also unable to have family members help with translation and serve as advocates because many hospitals have prohibited visitors due to the pandemic. All of these circumstances have likely only worsened health outcomes for individuals who are LEP, and this is unacceptable. All patients have a right, a legal right, to interpretation in healthcare facilities and we have to ensure that they are given access to equitable care. In addition, we have to endure that care is culturally humble and competent and tailored to meet the social, cultural, and linguistic needs of patients. Health inequities are pervasive in the American healthcare system and also similarly exist in New York City. For example, Black and Hispanic New Yorkers have desperate health outcomes and cancer related death, early diagnosis and treatment, and Black, Latino, and Asian-Pacific Islander populations have higher rates of diabetes than white populations. We also see desperate heath outcomes in maternal mortality and morbidity for black women. These inequitable health outcomes can

also be seen in COVID-19 health outcomes, and those who are older, lower income, Black and Latino are more likely to be hospitalized or die of COVID-19. This pandemic has highlighted so many inequities in our society, and one of the most obvious and glaring is inequities in healthcare. We, as a city and as a country, must learn from this pandemic and prioritize language access and equitable healthcare across racial and socioeconomic lines, and I look forward to hearing from H&H and others today about these efforts. I would like to thank the Hospital Committee staff, Counsel Harbani Ahuja, Policy Analysis, Emily Bulkin, Finance Analysis, John Change, and Data Analysis, Rachel Alexandrof. I'm going to turn it over to our Committee Council, Harbani Ahuja to go over some procedural items.

COMMITTEE COUNSEL HARBANI AHUJA: Thank you, Chair. My name is Harbani Ahuja, and I'm Counsel to the Committee on Hospitals for the New York City Council. Before we begin, I want to remind everyone that you will be on mute until you are called on to testify, when you will be unmuted by the host. I will be calling on panelists to testify. Please listen for your name to be called, and I will

be periodically announcing who the next panelists will be. For everyone testifying today, please note that there may be a few seconds of delay before you are unmuted, and we thank you in advance for your patience. All hearing participants should submit written testimony to testimony@council.nyc,gov. We have AISLE and Spanish language interpretation at today's hearing, so I request that all panelist testifying, please speak slowly so that our interpreters are able to provide interpretation. At today's hearing, the first panel will be representatives from the Administration, followed by Council Member questions, and then the public will testify. During the hearing, if Council Members would like to ask a question, please use the Zoom raise hand function and I will call on you in the order in which you have raised your hands. I will now call on Members of the Administration to testify. Testimony will be provided by Matilde Roman, Chief Diversity and Inclusion Officer for the New York City H&H. Additionally, the following representative will be available for answering questions, Margarita Larios, Associate Director of Health Equity and Language Access for New York City H&H. Before we

begin, I will administer the oath. Matilde Roman, and Margarita Larios, I will call on you each individually for a response. Please raise your right hands. Do you affirm to tell the truth, the whole truth, and nothing but the truth in your testimony before this Committee and to respond honestly to Council Member question? Matilde Roman? I'm sorry. I think you are muted. There we go.

MATILDE ROMAN: I DO.

COMMITTEE COUNSEL HARBANI AHUJA: Thank you. Margarita Larios?

MARGARITA LARIOS: I do.

COMMITTEE COUNSEL HARBANI AHUJA: Thank you. Matilde Roman, you may begin your testimony when you are ready.

MATILDE ROMAN: Thank you. Good afternoon, Chairperson Rivera and Members of the Committee on Hospitals. I am Matilde Roman, Chief Diversity and Inclusion Officer at New York City Health and Hospitals. I am joined by Margarita Larios, Associate Director of Health Equity and Language Access at Health and Hospitals. Thank you for the opportunity to testify before you to discuss access to language services and equitable care in New

York City hospitals during COVID-19. Health and Hospitals is a safety net for the uninsured and underserved in New York City providing healthcare services to over one million New Yorkers each year. Our mission is to extend to all New Yorkers comprehensive and equitable health services of the highest quality in an atmosphere of humane care, dignity, and respect regardless of their language spoken, immigration status, gender, sexual orientation, disability, or ability to pay. As such, it is a critical part of our mission to provide accessible, culturally, and linguistically appropriate service to ensure full access to comprehensive and quality care for all New Yorkers. At Health and Hospitals, patients who receive care belong to many different racial and cultural backgrounds. An estimated 30% of patient served are limited English proficient, and more than 60% of patients self-identify as that of Black, African American, Hispanic, Latin X, or Asian. That is why Health and Hospitals provides free language services 24 hours a day, seven days a week, 365 days a year, in over 200 languages and dialects. We translate patient documents such as consent forms and patient

education materials in the top languages requested by limited English proficient New Yorkers. Health and Hospitals is a leader in providing culturally competent and linguistically appropriate services. In fiscal year 2020, Health and Hospitals facilities received more than one million requests for interpretation services. That yielded 13 million interpretation minutes. Systemwide, initiative to support communication for persons who are limited English proficient include making available language access resources to inform the public of the availability of free language services and tools to ensure quicker access like language ID desk top displays and I Speak cards to support facilities in their delivery of language assistance services. Creation of an essentialized data base system to collect language service usage and key performance metrics to monitor for quality assurance and effectiveness and having a designated language practices coordinator at each facility who is responsible for overseeing the provision of language services. Our provision of culturally competent equitable health services are guided by an understanding of the important role of one's culture,

race, gender, and other social identity-based categories in interpersonal and professional encounters in healthcare, and awareness of historical and sociopolitical factors such as racism, ablism, immigration patterns, and human rights violations and their impact on the health and wellbeing of minor populations, and the value of collaborating with ethnic and racial minorities community-based organizations to ensure to appropriate responses to individual health needs. As mentioned, language services are a key component to eliminate barriers to care, improve patient safety, and enhance the patient care experience. As part of our ongoing efforts, Health and Hospital promotes patient's rights to language services by ensuring signage regarding the availability of free language services are posted in public areas. We distribute I Speak cards to patients and make available multi-lingual educational and marketing materials. When COVID-19 arrived in New York last March, hospitals everywhere had to quickly adjust their service delivery approach including Health and Hospitals. The pandemic ensured a rapid expansion of Telehealth and technological innovations at Health and Hospitals. With the

shutdown order in place and in-person ambulatory services significantly reduced, Health and Hospital Commissions turned to telephonic and video communication to serve the over half a million patients who rely on Health and Hospitals for outpatient care annually. One of the most emotionally devastating aspects of COVID-19 was the state mandated no visitor policy. While necessary to curve the risk of spreading the virus, the State's no visitor policy in hospitals and nursing homes nationwide were heart wrenching for patients, residents, families, and staff. From April to May 2020, Health and Hospitals deployed 1000 donated tablets across the system through a patient-family connection program. Over 500 video calls were made a day to keep patients and their loved ones connected and keep families abreast of their patient's status and care. The systemwide language interpretation services supported our virtual communication with families in 183 languages. For patients who do not require admission to the hospital, the system launched an at-home COVID-19 text message-based symptom monitoring program in the City's top 13 languages for patient discharged from the emergency

department. Enrolled patients get secured text messages every 12 to 24 hours to assess their symptoms in their language. True to our mission, Health and Hospitals puts its patient first, connecting them to languages services while providing safe and quality healthcare services. Health and Hospitals will continue to provide health services in a culturally responsive manner to meet the needs of the City's diverse population. Thank you for your attention to this important topic. We're happy to answer any questions that you may have at this time.

COMMITTEE COUNSEL HARBANI AHUJA: Thank you for your testimony. I'd like to now turn it over to Chair Rivera for questions. Panelists from the Administration, please stay unmuted if possible, during this questions and answer period. Thank you. Chair Rivera, please begin.

CHAIR RIVERA: Thank you so much for your testimony and I really appreciate you mentioning how difficult it was to pivot during the pandemic into providing as much care as quickly as possible, so I just want to thank you all for all of the work that you do and for all of the New Yorkers that you serve without question, openly and with the best quality

care possible. I want to just ask some questions about some numbers that you mentioned, especially during a hearing we had in fall 2019. So, patients who are limited English proficient experience adverse health outcomes than markedly rates than English speakers. During a fall 2019 Hospitals hearing, H&H testified that in fiscal year 2018, it fielded more than one million requests for interpretation services, and I think you went on to mention that was 13 million minutes of interpretation. What is the latest figure?

MATILDE ROMAN: So, they stay consistent. In between March and January of 2021, we have yielded more than a million requests for interpretation services in over 13 million interpretation minutes, and thank you, Council Member Rivera. I want to thank you for sharing your story and for your continued support and advocacy on behalf of immigrant New Yorkers. You are one of our conscious supporters and I just want to acknowledge all of your support.

CHAIR RIVERA: So, those numbers remain consistent, one million requests that is translated into the 13 million minutes hasn't increased during,

have requests for interpretation services increased during the pandemic?

MATILDE ROMAN: Ever so slightly. It's been consistent simply because of the patient population in which we serve. Many of those individuals are, as you know, are individuals who are vulnerable in the City. We are the safety net for the City in providing quality healthcare services and we know that language services are a critical component to ensure patient safety and quality, but also to tailor needs and ensure that our patients are receiving services in their language.

CHAIR RIVERA: So, you said only very little during the pandemic. Can you describe how the pandemic has effective the hospital's ability to provide interpretation and translation. Clearly, there must have been multiple challenges.

MATILDE ROMAN: I think the challenges were more in us being, I mean, the challenges for us have been more in making sure than in our Telehealth platform and our ability to create video conferencing bridges between family members and patients, and I think for us, it really allowed us to be very innovative in elevating our technology to really

ensure that we were connecting patients to families in ways that were meaningful. As far as volume was concerned, our volume is, other than the slight check, has been consistent and we have been monitoring the language services very rigorously to ensure that it maintains and will maintain the same standard of quality language services across the system, especially during the pandemic because we understood how important it was that patient communicated with their providers and to their families.

CHAIR RIVERA: So, you said it allowed Health and Hospitals to be innovative and you went on to say elevating technologies. What has changed in terms of the technology that you're using?

MATILDE ROMAN: So, I think it was just more augmenting the equipment that we currently use, so we had 1000 donated tablets that we were able to really use in order to have more equipment available for bridging interpretation services, so that was actually beneficial in being able to help provide more resources for sites, and you know, the services that we provide are multiple. We provide telephonic interpretation services, we provide video and remote

interpretation services and during the COVID period, those were the two media vehicles that we relied on to ensure that we were bridging the communication divide with our limited English proficient population.

CHAIR RIVERA: Do you still use Linguistica International?

MATILDE ROMAN: Linquistica International is an active vendor within our system currently, yes.

CHAIR RIVERA: So, the New York Daily News, they published a report in January. They published in January alleging that overseas workers at Linguistica International affirm that does contract with the City to provide interpretation services at H&H and DOE. They were being paid as little as $4.00 per hour. The workers were receiving inadequate training and that sensitive, personal, and medical information shared during calls was not being properly protected, and I know the City has described these allegations as being reprehensible according to the Daily News. So, what concrete has the City taken to address these allegations other than referring the matter to the Department of Investigation?

MATILDE ROMAN: Thank you, Council Member Rivera for that question. In response to the article, New York Health and Hospitals began an internal inquiry into the allegations made. This inquiry is ongoing, but I want to emphasize and share with you that we do very rigorous monitoring of language services. Just to ensure compliance of our vendor services, we do routine monthly data received monthly, which we analyze for usage and ensuring that they are meeting our key performance metrics. We meet regularly with our vendors to ensure that we are connecting and making sure that they are meeting their performance standards that we require of them to provide the highest quality care to our limited English proficient population and have our language practice coordinators on the frontline with the day-to-day operations at sites. We also have feed back mechanisms in place so that, you know, you understand how rigorous we are in our ability to monitor the quality of services and so we routinely monitor for compliance with our vendor services and to date, have found no basis to the allegations made with regard to the New York Daily News article.

CHAIR RIVERA: How long does a patient typically have to wait for language access services?

MATILDE ROMAN: We at Health and Hospitals are ensuring that we provide timely and effective services to our limited English proficient populations, and we use a variety of different methods to ensure that that happens, rather it is telephone, video conferencing, or even our on-site interpretation services. Our effort is to connect patients to language so that they can communicate with their care provider as quickly as possible.

CHAIR RIVERA: So, you don't know how long a patient typically waits?

MATILDE ROMAN: Our average is on demand. Our average connect time is 20 seconds or less.

CHAIR RIVERA: Has the pandemic increased those wait times?

MATILDE ROMAN: No. Our systems have been stable. We have actually ramped up compliance and our monitoring measures during COVID-19 to really insure that we've maintained standard quality services throughout the pandemic.

CHAIR RIVERA: So, in response to the pandemic, you ramped up the interpretation services in order to eliminate any delays in access?

MATILDE ROMAN: No, I think we ramped up monitoring significantly just to ensure that there was a continuous provision of language services. You know, our volume is massive, you know, we provide millions upon millions of minutes of interpretation annually. The vast majority of our patient population are limited English proficient. We know that this is a business imperative to have language services and make sure that it functions in a way to help the provider and the patient communicate, and so for us, the ramping up really was related to making sure that we were closely monitoring compliance and ensuring that we maintain the standard of language services throughout the pandemic as we've done pre-pandemic.

CHAIR RIVERA: So, I just want to make sure I heard correctly, you said that a patient does not wait longer than 20 seconds for an interpreter? Is that correct?

MATILDE ROMAN: For telephonic and video remote interpreting, our performance matrix is 20 seconds or less, that's our average wait time.

CHAIR RIVERA: Alright, I understand what you mean, but I feel like the person walking in asking for an interpreter, seeing someone, sitting down and picking up the phone and being connected probably does take about 20 seconds ideally, but overall, when a person enters one of your facilities, I mean, how quickly are they addressed? What happens if a person can't wait? I mean, 20 seconds is such a short time span, it's very impressive, but these are not the stories that we've heard from the patients at numerous hospitals across the city, and I'm sure one of my colleagues will speak to this, but what's the longest wait time?

MATILDE ROMAN: So, let me take a step back and tell you that we also have bi-lingual staff to communicate patients and help patient navigate through our system. So, it would be an understatement for me to just mention telephonic and video remote interpreting services, but what is unique about Health and Hospitals in many respects is that not only do we serve a diverse population, but

our workforce is as diverse and reflects the patients in which we serve, and many of the staff that work at Health and Hospital come from the very communities in which patients are coming to us to receive quality care. So, that is something that I believe is an asset and we leverage bi-lingual to help also in bridging and connecting people in a timely fashion, so to your point, you know, the 20 seconds or less connection times are really only for telephonic and video remote conference, but there's a variety of different ways in which we connect with patients to ensure that we are communicating with them in their language.

CHAIR RIVERA: Of course, bi-lingual staff is important, but by law, qualified interpretation is required. So, how is, I hear you saying people are coming to facilities, of course, people in our City, you know, low-income immigrant, diverse New Yorkers that depend on H&H for quality care, but how is H&H proactively reaching out to LEP communities, for example to ensure that they're aware of their vaccine eligibility?

MATILDE ROMAN: That's a great question, Council Member Rivera. I think, you know, as an

Administration in the City of New York, I think when all of us on this call, you know, our primary focus is to inform as many New Yorkers about how to, you know, take the proper, you know, public safety precautions, you know, where to go if eligible to receive a vaccine, and that is something that there's a citywide effort, Health & Hospitals is part of those efforts, and we use multi-platform, multi-lingual communication, public awareness campaigns to really push out that messaging. I think the other key aspect for us is leveraging community-based organizations, community leaders, and faith leaders to really be the trusted messengers in providing information to communities, especially onto certain communities which is where many of the individuals who come seeking care at Health and Hospitals, and so that's what we can do and continue to do until we've combated this virus.

CHAIR RIVERA: Thank you for mentioning trusted messengers and community-based organizations. Can you clarify in concrete terms how community-based organizations or CBOs, partnering with T2 are supporting the work of vaccine education outreach and administration in the City?

MATILDE ROMAN: So, let me say thank you for that question. We help to provide access to interpretation services and provide translation support in 15 languages and dialects and we have almost more than 1300 bi-lingual monitors and tracers who speak over 40 languages on the ground for Test and Trace Corp, and all sites have interpretation phones and sites have bi-lingual staff to help navigate individuals and provide language assistant services.

CHAIR RIVERA: So, you have community-based organizations that you've partnered with. Can you explain the partnership, can you tell me what you're providing the community-based organizations because these community-based organizations, and we can just look Williamsburg, which I mentioned where my uncle lives southside, and you highlight Puente, you have (inaudible), but they are also expected to provide services on eviction prevention and social services and you know, college readiness and taking care of our seniors and so, I want to make sure that the expectations that we put on them are rightfully supported. So, what are you concretely doing to empower them and support them in this work?

MATILDE ROMAN: Thank you for clarifying it so that I can further explain our very close collaboration and partnership with community-based organizations. We have approximately 30 community-based organizations in key neighborhoods to help support messaging out to patients about the vaccine and about testing and also have, you know, the measures that they need to take to keep safe, themselves and their family, and so, like Make the Road, Voices Latina, are some of the organizations, and QUAN are some of the organizations that we closely partner with and really communicating at the grassroots level to communities that's some examples of the CBOs.

CHAIR RIVERA: Alright, so, I'll come back with a couple more questions, but I know that my, let me just ask a clarifying question on that because I hear what you're saying in terms of the partnership being important, but what I would love to hear is maybe like some statistics, some data. You provided 7.8 million dollars of fundings for 38 CBOs in July 2020 for outreach around COVID testing and treatment. Can you confirm that no additional funding for groups have been added since then?

MATILDE ROMAN: Thank you, Council Member Rivera for that question. CBOs remain a vital part of our outreach efforts to educate the public about COVID-19. I don't have the information readily available to give you an exact number, but the steps that we can take, they provide messaging, the steps we can take to combat the virus, and they provide, you know, education about wearing a mask, social distancing, washing hands, and staying home if they are sick, and they service as a trusted messenger within communities, but I can always come back with you and provide more information about the exact numbers.

CHAIR RIVERA: That would be great. I mean, I don't think these groups can effectively do their job in vaccine outreach with that limited amount of funding. So, maybe if you could get someone to get those numbers for us, we would really love that. And so, I'm going to pass it to one of my colleagues who has been a real leader on this issue, and I just want to thank you for answering my questions thus far, and if that's okay with the Committee Counsel, I'd love to go to Council Member Menchaca.

COMMITTEE COUNSEL HARBANI AHUJA: Thank you, Chair. Yes, we'll turn to Council Member Menchaca for questions, and as a reminder, if any other Council Members have questions, please use the Zoom raise hand function and we'll call on you in the order in which you've raised your hands. Thank you. Council Member Menchaca.

CHAIR RIVERA: Let me just say, we've been joined by Council Member Ayala.

COUNCIL MEMBER MENCHACA: Hi, and Buenos Dias to everybody. Thank you, Chair Rivera for this hearing and this ongoing discussion and ever-growing problem with the Administration as a whole around language access and I'm really thankful for H&H being here today and answering these questions, and this is going to help us with budget conversations that we're having right now and policy recommendations, and to support you, to support our local CBOs, and I just want to put an emphasis on this last set of questions that so much is being put on our CBOs on the ground that are already doing so many other things in their mission statement, but taking on this pandemic has been a big burden, one that they are taking because they know that it will be a life-changing opportunity

for people who are LEP and are looking for information, and so really getting back to us on exactly how you are, infusing funding and resources so that they able to do what they need to do. So, thank you for that. I want to step back a little bit and ask a broader question about the efficacy and measuring the efficacy of all the language access tools that you have. How do you do that, and is it a periodic test of how well each of these pieces are working, how do you measure that, and when do you measure that?

MATILDE ROMAN: Thank you, Council Member Menchaca. I appreciate your support. I know that you are a starch advocate for immigrants and limited English proficient patients within the community and across the City. You know, we have very rigorous quality control measures in place for language services, you know, the one thing that is critical and essential for us from a perspective, looking at it from a patient safety perspective, looking at it from cultural competency, you know, language services are an essential took for us in order to bridge the communication that divide for individuals who are limited English proficient, and we strongly believe

that no patient should be denied or delayed services simply because they have an inability to speak English. So, you know, Health and Hospitals is committed to meaningful access to language services. So, we continuously monitor language services to ensure the highest standards and we do this by having data and analyzing it on a monthly basis. We analyze usage, we analyze our key performance metrics just to make sure that they are meeting our key performance metrics. We liaison with the vendors on a quarterly basis to do, you know, quality assurance reviews. We have also at our disposal a feedback mechanism that is located in across the facilities where there is an issue with or experience that is not standard to our standards, providers can immediately send a feedback form online. It come directly to the… (crosstalk).

CHAIR MENCHACA: If I could pause…

MATILDE ROMAN: Sure.

COUNCIL MEMBER MENCHACA: If I could pause in the middle of this review, and I think, what I'm hearing is that you do measure, the question is, can we get access to that information so that we can see the analysis and for ourselves, we can see how

the different components are working together. Would that be something you can share with us?

MATILDE ROMAN: Yeah, I think we can definitely share information about our data so that you can see more closely how we monitor compliance.

COUNCIL MEMBER MENCHACA: Okay, so let's walk over to another conversation that is happening on the ground right now with indigenous languages, and I know that we're focused on so many of the top languages like Spanish and Mandarin and Arabic and those that are making it into Local Law 30, but there are some indigenous languages that are showing up in our communities like Nahuatl or Mixtec and Quiche, all of these languages are incredibly limited in how we can, as a City approach and in a pandemic, how are you really focusing in neighborhoods that are showing up with these indigenous languages so that H&H can help support the mission that you are speaking of today.

MATILDE ROMAN: So, last year alone, Health and Hospitals provided 262 languages environments. Many of which, so, 70% of our patient volume is Spanish, and then as you go down, right, and so the top thirteen languages that are cover

approximately 90% of our patient volume, but to your point, right, there are emerging languages that come, that we need to address, so you know, you mentioned Quiche, Mixtec Bajo, Mixtec Alto, these are all, you know, languages that we cover because of the redundancy measures that we have in place, so we have multiple vendors in the operations of it, we're ensuring that we're creating coverage through these redundancy measures, and so that is our process to ensure that every single individual, regardless of language spoken is connected to services.

COUNCIL MEMBER MENCHACA: Okay, well, I think there's a discrepancy and so we want to get a sense of where that discrepancy is hitting, having access to this technology is one thing, but I think seeing how it lands on the ground is another, and I guess, you know, the next question is really some of the limited diffusion languages are more oral than written, and I think this is something that we are really just trying to get a grasp on, on health, immigration issues, education issues, the Department of Education, and so some of the written material that is circulated is just not enough. What video messages have been included in your outreach with

these limited diffusion languages, and what are the plans to include more of that video opportunities so people can hear it and listen to it in our communities?

SGT. KOTOWSKI: Time expired.

MATILDE ROMAN: Can I ask a clarifying question?

COUNCIL MEMBER MENCHACA: Absolutely.

MATILDE ROMAN: When you're talking, so I distinguish the translations of documents and the interpretations differently. Are you referring more to the citywide public awareness campaign that's happening through the vaccine command center or is it specifically about the services that we provided Health and Hospitals? I just want to make that distinction.

COUNCIL MEMBER MENCHACA: Well, I think I'm utilizing experiences that are coming from the vaccine operations, but should be connected to all hospital relationships, I think are happening both and people coming into the ER or connected to CBO relationships, outreach materials that you're doing. What I think we're trying to do with the Council is trying to figure out how this holistic approach is

actually holistic and that every, every interaction is a positive reaction and interaction by our community.

MATILDE ROMAN: Okay, thank you for that. I think we are strongly committed and continues to be so in finding opportunities where we can provide languages and especially for those who speak a language of lessor diffusion or less common languages. You know, the language of lessor diffusion poses not a number of challenges for the City of New York. One, they're emerging and so we need to catch up, but the other aspect of this is that there's a limited pool of interpreters always in these languages and these kinds of lessor diffusion languages where the market needs to catch up to the provision of these services. So, for us, at Health and Hospitals, because we are dealing with medical encounters and sensitive health information, it's really important for us to ensure the quality of the interpreters that we use, and so there is always that kind of gap between really making sure that, you know, we use medical interpreters that meet the highest qualities, but also keeping in mind the fact that as languages, you know, New York City, that's

why New York City is the greatest city in the world is that we have such linguistic diversity in New York, and you know, it's an evolving process for us as Health and Hospitals and that's why we closely monitor usage and language needs to accommodate for and find solutions, but and they are happy to explore recommendations that you may want to put forth to see how we can bolster that, but to notes, for interpreters and their qualifications and to be able to render communication between a provider and a patient, there is a requisite level of experience, skills, and competencies that's required to ensure the integrity of the rendering but also to ensure the patient's safety, and making sure they understand, you know, what's being communicated and that the provider understands and can communicate with the patient.

COUNCIL MEMBER MENCHACA: And to be honest, this is why I'm so thankful for sharing in this hearing. This hearing has, I think, exposed the nature of something like a market waiting for a market, and what can the City do to actually bypass this market driven thing, cause I think that's been the conversation when I think about immigration

services or access to education services and parents engaging with DOE, but now this pandemic is threatening our lives and so, I want to just go back to this idea that if we can approach this in a different way, what is the better, what is the best way to communicate to a limited diffused language speaker in the City of New York and what I'm hearing from you is that we have to wait for the kind of the highest standard and a technology access, but isn't someone that works at the hospital that is already trained, that is connected to the system, that speaks that language, the best way to ensure professionalism, quality control, access, immediate, and so if that's the case, and you can confirm with that, what is the hospital system, H&H trying to do to either get more resources or have more robust connections with CBOs so that there could be that kind of agreement and access?

MATILDE ROMAN: Thank you for that question. So, I think there's a number of things. One, you know, each method serves its purpose in overall operations of ensuring that we provide timely and effective delivery of language services, and as I mentioned in the testimony and I will emphasize

again, you know, Health and Hospitals, you know, we have individuals who speak patient languages, and so, I want to ensure that, and when we're looking at job postings, especially patient facing job posting where, you know, we have individuals and that we know, need to connect to service more quickly. We're very intentional about putting languages as a preference in a job posting so that, you know, we are looking for individuals who are local, who are from the community, and can speak their language, so we are doing all of these things, and will continue to do so simply because it is part of the core of our mission and values to ensure that all New Yorkers regardless of language spoken or ability to pay get access to quality healthcare services.

COUNCIL MENCHACA: Okay, I'm over time now, and I want to be respectful, and I want to say thank you to Chair Rivera and on this last point, I just want to say that it's not enough, and I think's that what we're just trying to understand what the gap is and where we can work with you to bridge of that gap of connecting more and more folks to jobs at H&H. You know, these are career ladders that people in our communities don't necessarily see, and so how

do we choose a way of access at a moment right now that has been so critical and people have taken on a burden in the neighborhood to connect to people and so how do we translate that moment of service that most times, is volunteer or like the story that Chair Rivera gave of her uncle relying on friends and family to do this work, it's a lot that someone takes. How do we professionalize that and give them, say thank you, let's bring you on board? Let's bring you into the system, let's train you in a whole different way rather than a posting on a website. So, I've learned so much this morning. Thank you Chair Rivera for being an incredible leader in this conversation, and as the Chair of the Immigration Committee, I want to continue to support you and the evolution of this system. Thank you.

CHAIR RIVERA: Thank you Council Member, I appreciate that very much. I just, I just want to thank you for being here. I'm just trying to maybe talk a little bit more in numbers and data. I think that we've heard from you a philosophy that is very, very agreeable, and that I think is very relevant considering that we all celebrate the diversity of New York City, absolutely. Why we're having this

hearing is because we know that language access has been an incredible challenge. It is documented. It has been in the press. We have antidotal evidence, we have our constituents that reach out to us, we know our community-based organizations don't feel supported, and so what I'd like to hear is something that goes a little bit beyond, I think no waits more than 20 seconds or when I asked, have requests for interpretations services increased during the pandemic, you said something to the tune of not really. There has to be more to your answer than that. You know, we maybe people haven't been coming in the past year as regular services when it comes to maybe non-COVID related care, but you certainly had thousands of people coming into your facilities requesting services. So, I guess to start with the first clarification of the 20 seconds, and I know you somewhat cleared it up, but I still don't understand, I don't understand the 20 seconds and I, honestly, don't believe that 20 seconds is the answer to how long people wait for interpretations. So, is the 20 second statistic you gave, is it for only inpatient care?

MATILDE ROMAN: So, our services are on demand. So, at Health and Hospitals the telephonic and video remote interpretating services is an on-demand service that is provided. We also have bi-lingual staff that can communicate with patients at each of our site locations, and so when I'm talking specifically about the 20 seconds to connect, it really is related to both the kind of technology piece of, you know, connecting, so if somebody picks up the phone and presses the dial, there is an immediate connection to an interpreter that can communicate with the patient. If it is through the remote, we have tablet that we use, and you can instantly touch the language spoke and connect with an interpreter through video remote and connect the patient. So, when I'm referring to the 20 seconds, it is related to the technology that we use to connect patients with an interpreter.

CHAIR RIVERA: And is that any language or only common languages, like the 13 to 15 languages that you mentioned, is that what the 20 seconds is or is 20 seconds for any language that someone speaks?

MATILDE ROMAN: That is the average time to connect, but it's for over 250 languages, dialects for telephonic interpretation services.

CHAIR RIVERA: So, what's the longest someone waits telephonically potentially for interpretation?

MATILDE ROMAN: So, it depends, right. I mean, so, the one thing to note in this space with this work is that these are human services that are being provided. They're actually humans bridging the communication that there is a conduit between a provider and a patient, and in that, you know, operations vary. It could vary based on peak hours; it could vary by surge. It could be to Council Member Menchaca's point, it could vary, you know, a language of lessor diffusion where there may be an increase in connecting with an interpreter. Those are variables that we encounter and that we mitigate to ensure that we're connecting patients to language services to receive the care that they need.

CHAIR RIVERA: Are there ratios determining which language a person needs?

MATILDE ROMAN: So, we have a number of resources available at our sites. We have the

language ID desktop display that somebody can point to their language. We issue I Speak cards to patients and then when they come in for their visits, they can present that, and we can immediately identify the language need. Our contact centers are equipped with language services to connect to call center operators with languages services to communicate with individuals seeking an appointment. We have individuals in our intake and registration who speak the language because their coming from their communities in which the services are being provided. Again, I want to emphasize that our methods are very in scope simple to ensure that there is language service coverage 24 hours a day, seven days a week, 365 days a year.

CHAIR RIVERA: I know, and I just want to thank you. You said 262 languages and dialects, 70% of the services that you provide, I think are in Spanish and again, I always appreciate real numbers, and you said having data and analyzing it on a daily basis is like the crux of what you all do to make improvements. So, if you have the data and you analyze on a… (crosstalk).

MATILDE ROMAN: On a monthly basis, so just to clarify. We receive data on a monthly basis that is analyzed to ensure that they're meeting our performance matrix. We also… (crosstalk).

CHAIR RIVERA: I understand, I understand the performance matrix, it's just if you have that data, I would just ask a few questions about, you know, were there interpretation services that increased and you know, it could have been, no, it's remained steady, it's increased 10%, it's actually went down over the past six months, because if you have the data and you analyze it, I just feel like a lot of what we're discussing today is like philosophical and it's emotionally based, and you know, I appreciate that. I really do because I don't think you can do this work without being passionate about the services that you're providing, but what we're trying to get to are some of the numbers so we can figure out how to best advocate for Health and Hospitals and to also make sure that as we hear from some of the community-based organizations in a little bit, that you can hear directly from them what they need from the city to help this mission and to help address all the inequities that we've seen, all of

the challenges and quite frankly, all of the mistakes that have been made when we should know what languages, specifically should be provided at certain sites because of an understanding of that community. So, let me just ask about complaints. Since it sounds like, you know, you're doing the best that you can and you're very proud of the work and I appreciate that, how do you handle complaints about cultural insensitivity and how do you handle complaints about poor language access?

MATILDE ROMAN: Thank you, Council Member for that question. So, we, at each of our facilities, we have Patient/Guest Relation offices and departments that are guided with being able to, you know, offer to mitigate and investigate grievances from our patients. We also have feedback forms online so that we can receive in real time information about any issues that may be happening in our system at any given time. So, with regard to the complaint process, they are embedded into our overall operations and those things are guided by the Patient/Guest Relation office. People can also reach out to use directly if need be, in order to connect and you know, learn about any issues that happened

when we encounter an issue rather it's coming from the City Council, it comes from the Mayor's office, we are quick to be responsive to any remediation or correction that is needed. Again, I also want to emphasize again that this is a 24-hour, seven-day operation and we work for the patient and ensure, you know, that we're providing the best care possible in their language.

CHAIR ROMAN: What are the feedback forms like? Are they paper or are they online?

MATILDE ROMAN: They're online. So, at every site, a provider can either provide accommodation about, you know, the interpretation service experience or, you know, if there was an issue, they can flag it for us, and we can then drill down and investigate and make any necessary corrections with our mentors.

CHAIR RIVERA: Well, I also ask because are the feedback forms translated?

MATILDE ROMAN: Well, these are internal. These are internal monitoring mechanisms in place for us.

CHAIR RIVERA: Well, the person that fills out the feedback form to either log a complaint or perhaps, even praise some of the staff in your facilities, how do they fill out the form? You said it was online, no?

MATILDE ROMAN: It's staff and providers. It's an internal document that we use to monitor across the system. So, it's an internal operation tool that we use.

CHAIR RIVERA: So, let's say, my uncle. He goes into Woodhull; he receives superb service. He speaks only Spanish, he cannot even read a feedback form in Braille, if it were available. How does he log those comments into Health and Hospitals?

MATILDE ROMAN: That's a good question. We have My Chart in Spanish that is the patient portal, but we also send out patient's surveys in the individual's preferred language. So, for you uncle, he would be receiving once he was discharged from Woodhull or had completed his outpatient clinical service at Woodhull, would receive a patient survey in his language to rate our services and to flag any issues.

CHAIR RIVERA: So, there's a patient survey. Would I perceive that via the My Chart App after I've gone to get a COVID test, so I know that they come in right away after you receive the service. How do you track and analyze the complaints, or I should say the feedback from the patient survey?

MATILDE ROMAN: So, the My Chart is the patient portal where individuals actively access. The patient experience surveys are something that sent, so they're not necessarily online, but given, you know, our patient population, there are a variety of ways in which patients get patient experience surveys just to understand the services and be able to provide feedback that help informs the opportunities for us to be able to provide better care to our patients.

CHAIR RIVERA: So, how do you track and analyze them?

MATILDE ROMAN: There is a process for us tracking and analyzing those informations and making any necessary adjustments to services to improve care.

CHAIR RIVERA: So, with those, for example, do you have, or how are they accessible for someone like my uncle or are they able to be read aloud by the app?

MATILDE ROMAN: So, no. I think that we would mail them, like for your uncle, right. There are a variety of ways in which disseminate that, so it's not just the online form. Like he would get it in the mail. He would usually get it… (crosstalk).

CHAIR RIVERA: Is that automatic or because you know that he actually isn't online?

MATILDE ROMAN: Well, we know, we know a number of things about our patients. They require various methods of how to message out, right. We have intimate knowledge about our patient population, and you know, it depends on the patient, the language, and how we distribute, but we do one, there's access, both online, but you know, we also do multiple messaging out and sending out communication so that there is a redundancy in place for us to make sure that we're receiving feedback from our patients with respect to the delivery of care.

CHAIR RIVERA: Is there any way to break down these complaints to better trailer training to

specific communities? As of 2019, this had not occurred.

MATILDE ROMAN: So, we are, can you provide clarification… (crosstalk).

CHAIR RIVERA: So, you have the complaints, you track and analyze them with your internal process.

MATILDE ROMAN: Mm-hmm.

CHAIR RIVERA: How do you break down these complaints to see, for example, the immediate community around Woodhull, have certain consistent feedback, comments, recommendations, maybe there are certain things that trend, how do you make sure that you are responsive to those complaints, rather it be language access, accessibility for people with disabilities, you know, wait times, it could be any number of thing, but specifically approaching this work with cultural humility, can you take those complaints, can you take the data, and can you tailer it to make it specific improvements to really, really support the immediate community or the patient population that frequently goes that facility?

MATILDE ROMAN: Understood. Thank you, Council Member for clarifying the question. So, I

think for us, it's important for us to always have a pulse of what's happening in the community and there are a number of different ways in which we do that. Of course, we're, you know, complaints will come in and we have access that, but I think the most important aspect of understanding the community needs is through our daily engagement with our patient, our community, our community-based organizations, our community leaders that are really the trusted source in the community to communicate. We also have bi-lingual staff at each of our site locations who we value as far as making sure that one, we're addressing the language needs of our patients, but two, that the services being rendered are culturally responsive to the needs of specific population. We have an array of trainings in this space foundation just to ensure that our frontline staff and our providers provide culturally responsive services to all of our patients and so, and the thing to note in this work, is this work is always evolving, and so, I value one, you know, you are telling us where there are specific gaps or areas of needing improving so that we can get better to provide the highest quality care to our patients. So, those are the

opportunities. I think the other thing is that we have been very intentional about engaging with our community partners in a way that allows for feedback on things that we can do better and we value those partnerships that we have with our CBOs, with our community leaders, with our Council Members who are hearing this information and then being able to relay it back to us, so if there are any specific concerns or issues that come through your door, I value that information because it only makes us able to work better, and you know, our immigrant populations deserve nothing less than our best.

CHAIR RIVERA: Agreed. So, I guess that some of the feedback that we've gotten from a number of constituents, individuals are on interpretation, and, so, I mean specifically with ASL. How many ASL interpreters work within Health and Hospitals?

MATILDE ROMAN: I'm not sure I can provide you with an exact number of ASLs, but I can share with you for American Sign Language services, we have in the, video remote interpretations have American Sign Language that is used for video conferencing. We've integrated this into our Telehealth platform to ensure that we have ASL

interpreters available, and we have vendors that do on-site ASL services to accommodate the need of individuals who we know need American Sign Language, but the other thing to note is that, you know, we go beyond American Sign Language, and American Sign Language is not universals. There are a lot of variants to sign language… (crosstalk).

CHAIR RIVERA: Oh, absolutely. No, I know, there's Mexican Sign Language, there's all different types of sign languages. I am asking specifically because you said you do rely on Council Members and others to give you some feedback, and so some of the feedback that we've gotten is on ASL interpreters. I hope you can get me the number of people within H&H who can provide that type of interpretation. We've also received some complaints about language access at vaccination sites. Of course, there have been some that have been H&H related and some that have been, you know, voluntary hospital system, so I will not ask you about anything that is outside of your immediate view, but also access to bathrooms and access to seating for those who might have some physical limitations or can't stand for a long time, and there have been some very,

very long waits; and I just want to acknowledge, we've been joined by Council Member Reynoso. So, can you speak to, I guess, as briefly and as factually data driven as possible, how do you go about making sure that you are providing the right, I guess, the minimal language interpretation for some of these communities at certain vaccination sites, and how are you also making sure that there is adequate seating available, that bathrooms are available, how do you make sure that you're responding directly to that immediate community?

MATILDE ROMAN: Well, thank you for raising these concerns to us. I don't have specific information that I can share with you at this time, but I'm happy to follow up and provide you with specific information related to the concerns that you've raised today.

CHAIR RIVERA: And were you able to get the other information that I asked about regarding the 38 CBOs that were funded back in July 2020, I asked if you could confirm that no additional funding for groups have been added since then?

MATILDE ROMAN: I can follow up on that as well. My understand is we are partnering with about 30; I'm not sure of the number exactly.

CHAIR RIVERA: Thirty-eight.

MATILDE ROMAN: Thirty-eight, and their goal is to, they're vital the outreach and the education, the public education that's going out into communities, but we can follow up regarding that.

CHAIR RIVERA: Do you know any of the groups in the list of 38?

MATILDE ROMAN: I believe that Make the Road is one of them, Voices Latina, Quan is my understanding, so we have, not off hand, like the numbers, but you know, there are 38 and we can provide you also with the list of the CBOs and that's with the… (crosstalk).

CHAIR RIVERA: Well, I've Health and Hospitals for this list many times and I finally did kind of receive a preliminary list and I mean, I was asking because… (crosstalk).

MATILDE ROMAN: Oh, I have, did you get Alliance for Positive Change, Arab American Family Support Center, The Korean Community Services, Make the Road, Single Stop, Voices Latina, South Asian

Council for Social Services, and I mentioned Quan… (crosstalk).

CHAIR RIVERA: Right, and so that's definitely some of the groups, and I was wondering, you know, this is a hearing on language access and equitable care, and I think that you've laid out pretty distinctly that you believe that the community-based organization involvement is going to be absolutely critical to continuing to roll out the vaccine, vaccination services in an equitable way. So, I just wanted to make sure I, you know, that you were kind of prepared. Like these are the groups that are doing the work for Health and Hospitals. We're not sure if they've been funded additionally since July 2020. You know, the need for social services has remained steady at the very least, if not increased because of the public health and the economic crisis that we're going through. So, I just wanted to know rather you were familiar with those groups, and what they were providing for their communities and I hope that we can all agree, and that we can all talk to our "friends" in the Mayor's office about adequately funding them and funding them right away because they can't continue to function

this way without financial support and I hope that you'll support some of the Council Members and everyone else who wants to make sure that they are getting funded. I guess, just my last question, cause I know there's a couple people here that would like to testify is, the one thing we don't have is information about how the funding was going to services related to vaccine outreach and education. Do you have any information regarding that since I know, July 2020, we were kind of in very different situations? We wanted to make sure people were getting tested, that they understood that there were services available for them to quarantine should they test positive, but since then, we have pivoted to this vaccine roll out outreach and education. Do you know how that partnership has changed?

MATILDE ROMAN: Well, Health and Hospitals is one part of a larger city effort that's driven by the Vaccine Command Center and DOHMH, so I can speak about Health and Hospitals and our efforts, but I can't speak specifically with regard to what's happening (inaudible) that you know, we are really making an assertive effort to reach as many people as possible through translations of written material,

public facing outreach efforts are being made that are led, of course, by the Vaccine Command Center and press, media, signage, internal communications are being pushed out both for staff as well as for our patients and the larger community, and so we will continue to do the outreach to ensure that everyone is informed, how to stay safe and where to go to for vaccines.

CHAIR RIVERA: Understood, understood. I just want to make sure; I think we agree that these groups cannot effective provide all of the services that they already provide and are expected to do vaccine outreach and education without properly being supported financially by the City. So, we did a precensus 2020, we funded the groups to do the work because they knew how to reach our hardest to reach communities and so I think that we are late to the game on implementing this same model for the vaccination. So, I hope that you'll help in advocating for that and thank you for being here and answering our questions to the best of your ability and thank you for all the work that's done on behalf of Health and Hospitals.

MATILDE ROMAN: Well, thank you, Council Member Rivera. It is an important topic, thank you for allowing me to present on helping our LEP New Yorkers.

CHAIR RIVERA: Thank you.

COMMITTEE COUNSEL HARBANI AHUJA: Thank you, Chair. I'm going to quickly ask if there are any other Council Member questions at this time. Seeing no hands, I'm going to thank this panel for their testimony. We've concluded Administration testimony and we will now be turning to public testimony. I'd like to remind everyone that we will be calling on individuals one-by-one to testify and each panelist will be given three minutes to speak. For panelist, after I call your name, a member of our staff will unmute you. There may be a few seconds of delay before you are unmuted, and we thank you in advance for your patience. Please wait a brief moment for the Sergeant at Arms to announce that you may begin before starting your testimony. As a reminder, we have ASL and Spanish language interpretation at today's hearing, so, I request that all panelist testifying, please speak slowing so that our interpreters are able to provide interpretation.

Council Members who have questions for a particular panelist should the raise hand function in Zoom and I will call on you after the panel has completed their testimony in the order in which you have raised your hands. I would like to now welcome our first public panel. Our first panelist will be Lloyd Bishop. You may begin your testimony when you are ready.

SGT. BRADLEY: Your time will begin now.

LLOYD BISHOP: Good morning, Chair Rivera and Members of the New York City Council. My name is Lloyd Bishop. I'm the Senior Vice President for Community Health Equity at the Greater New York Hospital Association. As you know, our membership includes every hospital in New York City, both voluntary and public. Thanks for the opportunity to speak to you this morning. Hospitals take their responsibilities to provide language access to patient very seriously, including during the pandemic. We and our members believe that healthcare is a human right and certainly if you can't communicate with your patients, you can't treat them. So, how do hospitals provide language access? You heard a lot from Matilde. Let me provide some context for the hospital community. Hospitals

operationalize language access by having protocols in place and by having designated language assistance coordinators to implement those protocols across the enterprise. Every hospital has procedures, and every hospital has a coordinator to implement them. Hospital systems usually have a system coordinator as well. In fact, you met one of them on the previous panel. While individual hospital plans may vary based on the community and the number of languages spoken, there are some basic components. You heard about telephonic and video services, having qualified interpreters, professional agency interpreters, and document translations. Hospital protocols also include conducting; this will get some of the question, conducting an annual assessment of the languages a hospital must address, conducting interpreter training, and placing language preference information in hospital records. These protocols are consistent with Federal and State Regulations. Hospital coordinators manage all of this, as you could tell, and also services for the hard-of-hearing, deaf, visually impaired, and blind. Last year was like no other. Our hospitals mounted the largest mobilization of healthcare resources in the

nation's history. We mourned every patient that died, but we're also proud of the brave men and women in our institutions who has successfully cared for over 143,000 hospitalized patients since the pandemic began. The hospital staff of whom we are proud, include those language access staff. So, having a basic plan in place, what I described, it allows a hospital to adjust, flex, and respond during surge times. From last spring, one of the major insights was the innovative use of video remote interpreting when visitation was prohibited at the direction of the State. This meant, quickly working with vendors to unlock devices. Imagine you have video remote interpreting devices, standard Telehealth devices, maybe… (crosstalk).

SGT. BRADLEY: Time has expired.

LLOYD BISHOP: Time has expired, so in closing, I'll say, thank you very much, and I'm happy to answer your questions and we can talk about vaccine sites as well.

CHAIR RIVERA: Okay, I don't know if there was, if there was like kind of anything you wanted to hit on, like, just to wrap up strong. I don't want to take that away from you.

LLOYD BISHOP: That's fine, that's fine. Thank you. So, in terms of the learning, it was the innovative use of technology especially when you have visitation that was prohibited and figuring out ways to do that. You have to do that on the fly. One of the things that we did, and I'll just take another few seconds, was we proactively reached out to our hospitals at the height of the pandemic last spring to ask how they were doing and what they were working on, and that was one of the issues, but I will just close and say that the basic structure that is in place is very useful and usable, no matter what sort of language access situations our hospitals might by facing; rather it is the standard hospital practice, dealing something with the surge, but also if you are staffing or managing a vaccination site. I will say that because of the directive from the State for hospitals to generally focus on their own healthcare staff and the lack of vaccine, not many hospitals have community facing sites, but it is those basic structures, and I'll say, including something I haven't mentioned, bi-lingual staff who were not qualified healthcare interpreters, but bi-lingual staff who can help navigate and help at the front

desk and do those kind of routine communications. So, with that, I'm happy to take your questions.

CHAIR RIVERA: Thank you, very much. So, during a Fall 2019 Hospitals Hearing regarding cultural competency, Greater New York actually didn't come to testify, and they did not provide written testimony, well, they did provide written testimony, let me correct that. Greater New York did provide written testimony and it stated in regards to patients who are LEP, that hospitals have policies and protocols in place and designated staff to coordinate hospital activities including process improvement to address any issues that may arise and is said that Greater New York supports these activities by convening hospital coordinators to share best practices and challenges and to collaborate with State and National experts in the field. How often do such convenings occur?

LLOYD BISHOP: We actually meet quarterly. We have been doing that for some time. It's the language coordinators and then we also do individual briefings on particular issues, but it's such an important issue, that we do meet with them on a quarterly basis.

CHAIR RIVERA: Have you identified any trends over the last few meetings, I guess, during the pandemic, these quarterly meetings that have prompted you to change, improve any of the services that you provided in regards to language access?

LLOYD BISHOP: Certainly, the interpreters certainly have. Part of the reason for the convening is that they can share information among themselves about what they are seeing and how they are dealing with it. That's one of the values of Greater New York convening our members, and I will say that after those initial meetings and telephone calls, there was a lot of sharing of information about how Telehealth, in general, could be used more effectively in terms of language access and how even the VRI, the video remote interpreting tablets could be used to enhance family communication when the family cannot come into the hospital, even if you couldn't connect at that moment to the general Telehealth platform. It helped with family communications. That's something that I think was one of the biggest learnings from the experience that, well, we're still going through.

CHAIR RIVERA: Now, was it still quarterly during the pandemic cause I would almost say like was that enough?

LLOYD BISHOP: In fact, we probably did not meet during that spring, that's why we reached out and spoke to, not every language coordinator, but as many as we could. The big systems including, you know H&H, who also serves on the body.

CHAIR RIVERA: Do you know how often translation services are requested on average at New York City hospitals? Do you have that data?

LLOYD BISHOP: I don't that data on average, no, I don't have that data, but certainly the Health and Hospitals is our largest system in the city, so you can certainly scale down from that. They were all incredibly, remarkably busy, so, but no, I don't have that data by hospital.

CHAIR RIVERA: Considering how large Health and Hospitals is compared to, I guess, the other systems under your portfolio, do you know how much hospitals spend on translation, interpretation, and other language services and do you know how, maybe how much Health and Hospitals versus maybe like Presby, New York Presbyterian?

LLOYD BISHOP: We haven't done a survey on this in a long while. If you look at the data from language telephonic services, maybe VRI, other things, I mean, a large place can spend, you know 10 million a year roughly, then scale down from that.

CHAIR RIVERA: You mentioned telephonic and I know that that's a big component considering, you know, over 200 languages are spoken in our great city, but do you think that the requests for interpretation services increased during the pandemic and would you say a lot of them actually do happen in person, and do you know how long, on average, maybe the shortest time and the longest time someone would have to wait to get an interpreter in person?

LLOYD BISHOP: So, I'm not going to answer much to your satisfaction in terms of specific data, but it really does matter about the modality of what's available, what the person might need during the surge, the surge of patients at the moment, but there are, you know, bi-lingual staff who are available. One of the innovations was the use of apps on phones tied to the telephonic service that the hospital might be using so that individual doctors also had those local translation apps. So,

it can depend on the number of patients at the time, but the idea is to at least begin those conversation in the appropriate language as soon as possible. That would be, of course, separate from the actually medical interpretation that would take place with a qualified interpreter either in person or through a telephonic device.

CHAIR RIVERA: Well, I appreciate you saying that because I think, you know, as someone who has experienced this, like myself, you know, being expected to be an interpreter without the technical expertise, it's really good to service. You know, I just remember being there with my grandmother and translating the questions, and is it fair to her, is it fair to the doctor…(crosstalk).

LLOYD BISHOP: Mm-hmm, absolutely.

CHAIR RIVERA: It was just things that will be missed, that will be misinterpreted. Are language translation services available at every vaccination site run by voluntary hospitals?

LLOYD BISHOP: So, again, there aren't many community facing sites at voluntary hospitals, but if a voluntary hospital is running a site, or will run a site in the future, that basic structure

would be used to provide those services, again, having a bi-lingual staff to help with way-finding and maybe registration, but when you get to the actual medical interaction, which would be the vaccination itself, you would have a qualified interpreter either in person or through some electronic means.

CHAIR RIVERA: Right. I guess my question, I just want to ask again about when someone is actually in the hospital, and maybe they're waiting a little bit longer to secure an interpreter for whatever reason, maybe it's dialect, maybe the current interpreters are currently with another patient, the longer time that a visit can take because of interpretation challenges, can that impact insurance and cost to a patient, the longer they wait for interpretation services?

LLOYD BISHOP: I mean, I'm sure there would be some impact on that, but that’s why hospitals rely not just on one, but on a mix of services, and I have to say that telephonic services and video remote interpreting gives you the ability to meet those language needs more quickly, and getting Council Member Menchaca's question, even for

those perhaps emerging or lessor diffusion languages. The telephonic services really are very, very helpful in those situations.

CHAIR RIVERA: So, is, is that a no?

LLOYD BISHOP: I mean, I guess, I'll say that's a, that's a, I'll guess I'll say that's a no because a hospital plan would need to have in mind what to do so we can reduce the wait times.

CHAIR RIVERA: Right, and just to go back to the question, realizing how large like H&H is, H&H probably serves the most diverse patient population, correct?

LLOYD BISHOP: They certainly have facilities around the city, yes, absolutely.\

CHAIR RIVERA: Cause I know the rest of the larger systems, Northwell, I mentioned Presby, I know they're smaller than Health and Hospitals, but I'm wondering how do other hospital systems, how do they do outreach to LEP communities?

LLOYD BISHOP: So, outreach and community health education is done in partnership with staff like the language coordinators who support, but also community affairs, community relation staff and then with clinical staff depending on what the program

might be, and those community affair functions also include bi-lingual staff who come from the community, so the work there is to discuss those issues with ongoing community partners and provide information to those community members in the language in a culturally appropriate way using the advise and knowledge that a hospital has about its community.

CHAIR RIVERA: How do you let patients know about like their right to complain, their right to receive culturally appropriate care including translated health services acts. Health and Hospitals, they said there's a, like a survey that patient's get and though it might come in multiple languages, it's not the most accessible way to provide feedback, and again, it could be critical, it could be very, very supportive positive. So, how do you gather that feedback and how often do you take that feedback, analyze it, and try to make appropriate accommodations, changes and improvements to serve that adjacent community of that facility.

LLOYD BISHOP: So, in terms of notifying; I'll put aside the routine, you know, sort of community engagement that would happen. There's a patient bill of rights that walks through patient's

rights and the expectations of the hospital and that is provided by the State government. The State does it in the top six languages; that's one of the areas of frustration, so hospitals often have to translate that into other languages, but in terms of patient satisfaction, I guess there would be a team of people who would figure out the appropriate way and in the appropriate language and modality to reach out to individual patients and examen the feedback. Part of this work, part of the work of the language assistance coordinator in the hospital is to annually sort of analyze what is happening and to, you know, make some adjustments based on that feedback, but I think it's team approach and it is part of the hospital patient satisfaction process that happens routinely.

CHAIR RIVERA: So, what's the predominant way that you gather this feedback or these complaints?

LLOYD BISHOP: So, it would be the patient satisfaction form that come in, and to the extent that there are complaints at large at the moment, it would be those Patient Relations staff that was mentioned earlier who also would provide

that feedback, and all that would be sort of collected and discussed and sorted out.

CHAIR RIVERA: Do you know how many of the patient satisfaction forms you get, like in a year or in a quarter?

LLOYD BISHOP: I do not, but I'll be happy to let you know about that. I'll get back to you on that.

CHAIR RIVERA: Okay.

LLOYD BISHOP: I can get you an average or a range or something.

CHAIR RIVERA: No, I would just love to know. I mean, I have Legislation that would create a specific office to try to gather this feedback and then you, in order to make appropriate changes and accommodations at some of our city facilities, but you know, we can talk about that another time. So, in terms of, I just have a couple more questions. Are there any training specifically about the importance of language access and how to provide care to those who are LEP within the system, and how were there implicit biased training going?

LLOYD BISHOP: Okay, so, the… (crosstalk).

CHAIR RIVERA: And in terms of like, when I asked about training specifically, about the importance of language access and how to provide care to those who are LEP, I just if you could just answer the implicit biased training, how that's connected if at all, and rather there are within those trainings, really enough information about cultural competency as it relates to individuals with disabilities?

LLOYD BISHOP: So, in terms of training for LEP, I won't bother to mention the training that the qualified interpreters go through, but there is certainly training that hospital staff will go through, so they are aware of the language services at the hospital office, and they know how to access it. In terms of cultural competency and implicit biased training, that goes on at hospitals in various ways rather it is at the onboarding process, rather there are grand rounds where speakers are brought in and talk to doctors and nurses about those kind of issues, online training that is offered. We offer, Greater New York offered, some online training for our members, and we are in the process of retooling that and it includes both general cultural competency and implicit bias, and it's going to be all online

and not in person this time. And I'm sorry, and part of; and there are various components of that training, I forgot the past point, cultural competency generally, implicit bias, certainly language access, certainly disability issues, and frankly, LGBT issues as well. It has a number of components.

CHAIR RIVERA: I appreciate that. I did have a question about care for LGBTQ communities, and specifically individuals who are TGNCENBY, but I appreciate you mentioning that. You know, I think I'll stop with questions and we'll go to Council Members and see if any of them have questions for you, but I just, I just like to say, we'd love to see more data about the use of language services at hospitals across the board. Also, if you are collecting this data at every hospital, we'd love to see information on, you know, those patients who are identified as people with disabilities, on race, on ethnicity, on gender and that’s really just to connect to the larger discussion of equity within each of our hospital systems, and you know, Northwell is a very, very big system and so is Health and Hospitals, but there are still large diverse

populations walking into each of these facilities and we're really just trying to get at how can we create an experience that is culturally humble, that is relevant to the person walking in and that utilizes the community relationships in a respectable way because understanding the nuances and really the culture and the traditions within each of these communities is so, so important, and I understand we've been completely overwhelmed over the past year, but we already knew that diversity in New York City was alive and well, and so the more information and data that you can get regarding some of those services, some of that, I guess, aggregated information within the hospitals, it would be incredibly, I think, beneficial to everyone so we can advocate appropriately, and with that, I would just say thank you for answering my questions. Thank you for being here and waiting, and I don't know if, Committee Counsel, if there's anyone else that would like to ask questions.

COMMITTEE COUNSEL HARBANI AHUJA: Thank you, Chair. I'd like to ask if any other Council Members have questions at this time? I'm not seeing any hands. I'd like to thank you for your testimony.

We're going to be moving on to our next panel. In order, I will be calling on Hallie Yee, followed by Sara Kim, followed by Lori Huang, followed by Saba Naseem. Hallie Yee, you may begin your testimony when you are ready.

SGT. BRADLEY: Your time will begin now.

CHAIR RIVERA: They have not been unmuted.

COMMITTEE COUNSEL HARBANI AHUJA: I think we might be having some technical difficulties. We'll circle back to them. We'll start with Sara Kim. You may begin when you are ready.

SGT. BRADLEY: Your time will begin now.

SARA KIM: Hi, good morning. Hi, good morning. My name is Sara Kim, Program Director for the Public Health Research Center at the Korean Community Services. I really appreciate the Chairperson Rivera and Members and staffers for the Committee on Hospitals for giving me this opportunity to testify before you. First off, thank you all Council Members for timelessly working to fight against the COVID-19 and make tremendous efforts to bring back New York City stronger. Briefly introducing, KCS was the first and largest community

organization serving the immigrant communities throughout the five boroughs abided by mission to be a bridge for Korean immigrants and the wider Asian community to fully integrate into society and overcome any economic and linguistic barriers. We respond to our client's needs nearly 15,000 monthly, both in person and remotely from seven locations y delivering home meals to homebound seniors, making daily assurance calls, arranging meal services for patients, assisting with food stamp applications, helping low-income immigrants to sign up for NY Care, Obama Care, and Medicaid, hosting vital hepatitis B testing and mobile mammogram, handing out fliers about COVID-19 prevention and testing site information. We run numerous services and programs. As a(inaudible) test and trace community engagement, we've partner with other (inaudible) to provide cultural tailored prevention messages on streets and virtually across Queen, from corner neighborhood down to (inaudible). Our team is greatly proud of this critical work to our community member's health and safety. While we have been involved for the past seven months, we could observe some areas in need of improving; language accessible for APA communities.

First, testing sites need to consider language services if they serve a high presence of Asian populations. Lastly, KSC has composted a mobile testing event with hospitals at our community center located in (inaudible) Queens. In this neighborhood, 35% of the residents are Asian immigrants. At 10 testing sites, no one spoke Asian languages as expected. Korean and Chinese elderly needed our language assistance to understand what they should do for testing registration, and how to get their test results. To help the people lining up for testing, we set up a table for language services, mask distribution, and NY Care promotion. For weeks, many people gave a positive feedback to us, second, in regards to tracing, my co-worker's mother contracted the virus while working at a nursing home. She received a positive result and later received (inaudible) contact tracer. She hardly spoke English, so she asked her son, Michael to…

SGT. BRADLEY: Your time has expired.

SARA KIM: To communicate with the tracer. My colleague explained that his mother didn't speak English, therefore, the tracer connected the Korean interpreter to his mother. According to

his mother's reflection, the translation service was not done well because the tracer seems not fully trained in connecting a translator and communicate in three ways. After the first call, she had to respond to daily check in calls or text messages over two weeks, but all the messages were written in English. She had to entirely depend on intimate family member's language assistance. This (inaudible) after his mother got sick, one week after, his father showed symptoms and got tested positive. My colleague working as (inaudible) for weeks. Thank you. Yeah, thank you very much for this opportunity.

COMMITTEE COUNSEL HARBANI AHUJA: Thank you for your testimony. We'd like to now welcome Hallie Yee to testify. You may begin when you are ready.

SGT. BRADLEY: Your time will begin now.

HALLIE YEE: Thank you, and my name is Hallie Yee and I'm the Policy Coordinator at the Coalition for Asian American Children and Families. Thank you, Chair Rivera and Members of the Committee on Hospitals for giving me this opportunity to testify. Just to start, some statistic. Asian Americans in New York have the highest rate of

linguistic isolation of any group at 42%, and half of most spoken non-English languages in the City are Asian American. COVID-19 has highlighted the barrier that most marginalized ABA spaced language access. The mere availability of languages is not enough without effective outreach and implementation of language access policies. It prevents vital communication about any decisions around the pandemic from reaching our communities. We've been told by numerous community members and organizations that there is so much confusion around languages rights that exist at COVID testing and vaccination sites. It took us nearly three months to get a single slide on language rights at testing rights from Health and Hospitals and are still waiting on those for vaccines. I've been lucky enough to get my vaccine and I got to see firsthand just what our community members meant. I saw one sign in English stating availability of Language Line and nothing else. I've also be unlucky enough to be hospitalized for COVID and witnessed a woman who spoke Arabic wait nearly two hours in an emergency room for an interpreter. Much longer than the New York City Emergency Room interpreter law requires at under 20 minutes, and

that's a top 13 language. I can't image what others are going through. All forms, as well, at vaccination sites, I'm being told by our community members that are all in English. We sacrificed equity in the name of efficiency and that's not going to be effective in the long run. To fix this, the city needs to ensure that interpreters and easily found materials for all languages spoken, that vaccine and testing site information are translated into commonly used and less visible languages in the community. We need on-site interpreters as much as possible at both testing and vaccination sites. Telephones for commonly used languages should be available, but the City needs to work with our CBOs more to recruit those who can actually interpret and be trained to do so, especially with our low incident languages. We need to regularly release accurate data from New York State and City on ways that ethnicity, language spoken, and disability. We need to know that the State and City is collecting data on vaccine distribution by ZIP code, age, race, ethnicity, occupation, language spoken, and other factors. If we don't know whose unvaccinated, we can't achieve equity and target and tailer

interventions based on the reasons for disparities. The delay of disseminating and general lack of in language information about the pandemic, including social distancing guidelines and the most basic of information has led to a higher risk of exposure to the virus for the most vulnerable in our communities. This egregious gap in language access has led to our communities to rely once again… (crosstalk).

SGT. BRADLEY: Your time has expired.

HALLIE YEE: Upon the community-based organizations to serve them in the absence of proper resources by the city, as CBOs act as interpreters and crowd sourced translated materials regarding the most basic information on the pandemic. Outreach to the marginalized pockets of the community must be prioritized. Without it, their health and very lives are in endangered if they are unable to communicate with their schools and healthcare providers. Our community will continue to suffer every day we allow these flaws in the system to exist, but as always, CAACF will continue to be available as a resource and partner to address these concerns and look forward to working with the City to continue addressing these inequities se see day in and day out. Thank you.

COMMITTEE COUNSEL HARBANI AHUJA: Thank you for your testimony. I'd like to now welcome Lori Huang to testify. You may begin when you are ready.

SGT. BRADLEY: Your time will begin now.

LORI HUANG: Good morning. My name is Lori Huang, and I am Outreach and Health Coordinator at United Chinese Association Brooklyn. So, thank you Chair Rivera and Members of the Committee on Health and Hospitals for giving us the opportunity to testify today. So, just to start with a little background. United Chinese Association Brooklyn is a non-profit organization that was founded to mobilize community resources to improve the quality of life for the Chinese immigrant population in Brooklyn. We house one of the largest number of Chinese born residents in the city where more than 60% have low English literacy levels and over the past decades 95% of our clients are immigrant families and over 80% of those are low-income residents living under the Federal poverty level. So, as we can see that COVID-19 has exposed some deeply rooted disparities across the healthcare system which disproportionately impact the vulnerable communities and there should, I think illusive innovation coming in outreach and policy and

a passion for fighting for an equitable future, and we know that in some situations, that more than half of the population have limited English proficiencies which is preventing some from having access to a timely COVID-19 information and care. So, the Asian community includes many individuals who may be afraid to seek testing and care at the hospital like due to language or cultural barriers. Problems in assuring language access are new, but unfortunately, they are just one more problem in healthcare disparities that has been ignored for far too long and now compounded once again in this pandemic. So, for example, like there are reported situations like not always having access to an interpreters or interpreters that don't always speak their languages, and they might also feel a little uncomfortable or unwilling to share this sensitive personal information like racial or ethnic origins with worries about receiving prejudicial or unequal treatment, especially with the new wave of hate and continued racial injustice that we see in our society right now. So, this can further lead to uncertainty to secure treatments in certain, like, healthcare facilities and because there's like struggles to communicate with medical

professionals and also with the fear of like, healthcare cost and this can also delay some COVID-19 testing and treatments in some Asian communities. So, that's why most of the time, they would rather like, visit the local clinics or go to the primary care provider to seek some basic care and feels skeptical insecure about like, going to the hospital at the moment. So, in order to fight for language access service and health equity during the pandemic, we should definitely, actively reach out to the patients… (crosstalk).

SGT. BRADLEY: You time has expired.

LORI HUANG: Experience structural racism and working as a community to help patient get the care that they deserve and that they need (inaudible).

COMMITTEE COUNSEL HARBANI AHUJA: Thank you for your testimony. I'd like to now welcome Saba Naseem. You may begin when you are ready.

SGT. BRADLEY: Your time will begin now.

SABA NASEEM: My name is Saba Naseem and I am the Assistant Director of SAPNA-NYC. Thank you Members of the Committee on Hospitals for giving us the opportunity to testify today. SAPNA is the only

CBO in the Bronx that offers linguistically accessible and culturally attuned programming and services to Pan-South Asian community. Our community has grown significantly in the last decade, yet resources and funding remain low. COVID-19 has highlighted the barriers our South Asian immigrant community faces in language access in the City's Health and Hospitals systems. Throughout this entire pandemic, language and digital access barriers have made it difficult for our communities to understand the virus and health recommendations. Government policies around the pandemic, test inquiries, and now, vaccinations. In fact, this lack of language access and cultural competency has led to a higher risk of exposure, infection, and mortality. As a trusted CBO that has invested in building relationships with the community we serve, our community has turned to us as they continue to bear the brunt of the pandemic. From the very beginning, SAPNA has been creating and disseminating materials around COVID-19 and related policies to the community in ways we know will reach them immediately, and now SAPNA is doing that same work around vaccination, educating on the vaccine itself, addressing fears and

hesitancy, and helping our community understand eligibility and how to make appointments. Already, we see the discrepancy in vaccines administered with low-income communities of color being vaccinated at lower rates despite being the most vulnerable and most impacted. Just the other day, one of our older community members came to get food from our pantry. When she came inside to say hello, we asked if she had made a vaccine appointment as she is eligible. She had been coming to use for years now for various services and trusts our staff. She related her fears around the vaccine, so we assured her it is safe and let her know what to expect. Given her limited English and computer skills, we scheduled her appointment right then, and today, she is happily vaccinated. Unfortunately, there are so many others like her who have not received trusted information, do not have English proficiency or literacy to book their appointments by themselves online. We ask that the City and State ensure that critical information gets to families in the language they need and understand. We also ask that the City and State invest resources and funding in small, trusted Asian-Pacific American CBOs like SAPNA that are on the

frontline reaching the most marginalized communities to ensure their health safety and livelihood. Thank you for this opportunity to testify and we look forward to working with the City Council to ensure that all New Yorkers have access to the services and support they need.

COMMITTEE COUNSEL HARBANI AHUJA: Thank you for your testimony. I'm now going to turn it over to Chair Rivera for questions.

CHAIR RIVERA: Thanks to all of you. Thank you so much for being here to testify, and I appreciate you sharing some of the stories. I think I try to be as clear as possible, you know, how we all know that language access has been a real challenge over the past few month, even pre-COVID, so there were specific examples. Ms. Kim, if I can just ask you a question about you said that there was site where there was really no adequate interpretation available that maybe someone on your staff had visited. You mentioned this was in the borough of Queens. Is that right?

SARA KIM: A testing site.

CHAIR RIVERA: Yes.

SARA KIM: Yes, we proactively work with Queens borough to be more appropriate site for Asian Americans in our neighborhood. We kept asking would they be able to have a hospital testing event. So, when they came in, we found that more than 10 staff members don't speak any Asian languages and that's why we provided our staff members for language assistance.

CHAIR RIVERA: And I thank you very much for that. Has the City or any of these systems tried to support you, maybe financially or compensate some of your staff time or are you doing on your operational budget as it stands?

SARA KIM: No, we didn't get any compensation for this work, but yeah, because we care for our community members. That's why we voluntarily support them.

CHAIR RIVERA: I know, and I thank you for that, and I know that this is one of those moments in our history where we all have to give everything of ourselves, but I also realize how difficult it is to run a non-profit organization during a fiscal crisis, so I have to ask. Thank you very, very much. I just had a quick question for Ms.

Yee. Are you still with us? Okay, thank you. You mentioned also in your testimony that you happened to be at a Health and Hospital facility, unfortunately witness, I think, an Arab American woman waiting two hours for interpretation? Can you just like speak to that for as long as you think is appropriate and can you tell me which site it was, which community, which neighborhood maybe?

HALLIE YEE: Yeah, for sure. So, I live in Brooklyn. I think it was Kings County. Essentially, I understand that like, we were in, like, the kind of waiting section for all the people that had COVID, and we're waiting to be seen. She, in the hour and half that it took me to be seen, she had not been spoken to. She was still waiting for telephonic interpretation and had not been provided with it by the time I left which was about two hours, and I noticed also, there were a couple of individuals that like, even like, Spanish-speaking individuals that seemed to have been waiting there for about an hour for interpretation as well, and it was just very alarming because it was an emergency room setting, so it's seems to be something that

should be even more urgent than other areas of the hospital.

CHAIR RIVERA: Oh, absolutely, and I agree with you. I just want to thank you for sharing that because you know, I realize we're all completely, you know, in over our heads in many aspects, but I just found some of the answers from Health and Hospitals on how long typically someone has to wait, irrelevant, and you know, just not factual. So, thank you. Thank you very much for all that you do, thanks to all of you, and another comment that was made about crowd sourcing materials and us all depending on each other for interpretation which is effective and does result typically in materials that are, I think, not just correct, but culturally appropriate, but I realize that that should not be on you all to consistently have to not only interpret but translate everything. So, I hope that, you know, with this hearing, there will be another further sense of urgency on the services that you provide and that you'll be supported to not only deliver on your daily mission, but to really feel like we are grateful to you for all that you have done over these past few months. So, thank you,

thank you all, thank you for time, thank you for your testimony, and with that, I'll turn it back over to the Committee Counsel.

COMMITTEE COUNSEL HARBANI AHUJA: Thank you, Chair. I'd like to ask if any other Council Members have questions at this time? Seeing no hands, I'm going to thank this panel for their testimony, and we'll be moving on to our next panel. In order, I will be calling on Erick Agarijo, followed by Rehan Mehmood, followed Mon Yuck Yu, followed by Anika Childrey. Erick Agarijo, you may begin when you are ready.

SGT. BRADLEY: Your time will begin now.

ERICK AGARIJO: Good afternoon everyone. Thank you to Chair Levin and Rivera, and Members of the Committee on Health and Hospitals for giving us the opportunity to testify today. Just a little about myself. My name is Erick Agarijo. I am Community Outreach and Communications Coordinator of the Korean American Family Service Center. KFSC provides social services to immigrant survivors and their children who are affected by domestic violence, sexual assault, and child abuse. So, all of our programs and services are offered in culturally and

linguistically appropriate setting, and keep in mind that 98% of our clients are immigrants and 100% of our staff members are immigrants themselves or children of immigrant parents, so over 95% of our client's first language is not English, and they come from low-income backgrounds. Throughout New York State, when it was on pause and throughout the COVID-19 and public health and economic crisis, KFSC responded to a 300% increase in calls to our 24-hour bi-lingual hotline. Now, these 88% of these phone calls were related to domestic violence and sexual assault and child abuse. Between April and August 2020, we responded to over 1500 hotline calls and KFSC served 915 individuals and provided 19,802 services related to domestic violence and sexual assault. So, our frontline and essential workers met the increased needs and provided in person crisis intervention, counseling, case management, and other supported services, all in a culturally and linguistically appropriate setting, and these challenges due to limited English proficiencies exacerbated already existing issues due to family violence at home, poverty and cultural differences. Particularly, the COVID-19 pandemic and subsequent

closing of schools and businesses, highlighted this gap even further. Many survivors were excluded from accessing unemployment insurance, did not know how to navigate the healthcare and hospital systems in the US due to language barriers. So, as an organization that provides shelter, our frontline staff have been navigating the vaccine appointments and its processes for immigrant shelter residents who are unable to do it on their own. However, even for our staff members, it was extremely difficult to navigate and unable to make appointments in a timely manner, but we do understand that this is a new system for all, but for the immigrant survivors, this is just another hurdle to overcome during this challenging time, and we ask, we must make the process accessible and user friendly for the immigrant survivors and their families, and one way to do this is to make sure that the language access is in place. Once again, thank you for this opportunity to testify for you today. We look forward to working with all of you to establish an effective system for all of our immigrants and immigrant survivors. Thank you very much.

COMMITTEE COUNSEL HARBANI AHUJA: Thank you for your testimony. I'd like to now welcome Rehan Mehmood to testify. You may begin when you are ready.

SGT. BRADLEY: Your time will begin now.

REHAN MEHMOOD: I'm Rehan Mehmood, Director of Health Services at South Asian Council for Social Services (SACSS). Thank you for this opportunity to present our work to the honorable members of the Committee. Our major areas of focus are healthcare access and benefits, particularly senior support services. We also provide free English and computer classes. Our competent staff speaks 18 different languages which include 12 South Asian languages, Indi, Bengali, Urdu, Punjabi, Napoli, Gujarati, (inaudible) Marathi, Telugu, Tibitan, Tamil, and we also speak Cantonese, Mandarin, Malay, Creole, and Spanish. In 2020, we served over 25,000 school or programs. The COVID-19 pandemic has reaped havoc with the lives of our communities. Food and security, hunger, and medical services have become the most pressing needs. Every week, we serve 5000 individuals through our programs. SACSS has translated and distributed literature on

COVID-19 testing and vaccination in various different languages to underserved communities living in many neighborhoods of Queens. Our staff has tables outside many stores, subway lines, and bus stops providing vital information in different languages about prevention and resources available to everyone during this pandemic. Rumors about public charge, especially during the peak of the pandemic created more fear and more disparities in communities who were already going through a lot of emotional and financial stress. It was CBOs like SACSS who increased their outreach efforts and made sure that the right information in the appropriate language that the client speaks is provided so that they can use all the methods available to them without any fear. Agent program NYC Care which provides access to healthcare to those who are undocumented or underinsured has become a major success. Thousands of clients throughout New York City have benefited from this program. One of the major reasons of our success in spreading of the word is that we provide information to clients in a culturally and linguistically appropriate way. Using these skills and creating a collaboration between CBOs and

hospital systems, we can further create a better way of making sure that every New Yorker has access to information in their own language when they enter a medical facility in this community. I would just like to share a small story. We had a client that hadn't visited a primary care physician for nine years, had never seen a doctor, spoke Spanish, information is available out there, but it was never presented to him in a culturally competent way that he could understand the system. The feel was still there that I might get deported. The feel was still there that if I go to a doctor, there might be ICE standing out, so we CBOs, everyone like on collaborated together, make sure that our communities understand the systems, and then they also like benefit from the facilities that are available. Thank you so much.

COMMITTEE COUNSEL HARBANI AHUJA: Thank you for your testimony. I'd like to now welcome Mon Yuck Yu to testify. You may begin when you are ready.

SGT. BRADLEY: Your time will begin now.

MON YUCK YU: Thank you for the opportunity to testify. My name is Mon Yuck Yu,

Executive Vice President at the Academy of Medical and Public Health Services in Sunset Park, Brooklyn. We are a public health organization that works to bridge the health equity gap for Latino and Asian populations through health and social services, and here is what we see the language access gaps in our public hospitals looking like. In March of last year, a community member tried to visit H&H to get seen because she was experiencing COVID-19 symptoms. She had never learned to read or write in home country. She encountered an English-speaking receptionist and was told she should not be there. She would not offer translation and left. Only when she approached AMPHS was she later connected to a physician who diagnosed her with COVID-19 and diabetes but does not want to return to the hospital due to her experience there, and despite the fact that Sunset Park has been names a party neighborhood in the City's vaccine For All effort. Vaccine uptake remains at only 4%. Many of our immigrant community members struggle to navigate the city's vaccination scheduling system with limited English and technological proficiency. At the Sunset Park vaccination site, we have been fortunate enough to

work with H&H with vaccine blocks, connect local communities of color to vaccines. We developed our own translated vaccine appointment forms and called those who were technologically disenfranchised in the languages to break down access challenges. Even through they're connected at the point of access, there are estranged at the point of care. Mr. Wong is an 80-year-old man who has diabetes, lives alone, and walks with a limp, and only speaks Chinese, and for months, he was unable to get a vaccination appointment until he connected with us, but when he reached his site, he waited two hours online and was then told he was not on the list to stand inside a long line of other Chinese and Spanish speakers to complete paperwork that's entirely in English. He waited in the cold until he could wait no more for five hours, and when he called us, he said, "This is unfair. This is too frightening, and I don't want to get the vaccine anymore". These language access issues are the exact reason that there is vaccine hesitancy of communities of color. When I visited the vaccination sites last week, here's what I saw. None of the signage nor registration forms is translated into other languages. There are no staff

members on site speaking other languages. Instead, we were told to tell community members to bring their own translators if they can. There is no signage telling community members they have the right to language support, and there's only one language at the kiosk that's not even visible heading indoors. Our non-English speaking seniors were afraid of the possibility of standing in line and not be given accommodations for priority service because they cannot communicate regarding their needs and ended up counseling their appointments, and our community members are feeling scared, frustrated and confused. This process is perpetuating the systematic racism that's been in our current healthcare infrastructure. Even though we've help community members move pass the point of access, challenges exist at the point of care. Non-English speakers are being treated different and set to the side where English speakers are shown they have more privilege. It generates hesitancy to get a second dose, it creates a stress that hospitals and CBOs… (crosstalk).

SGT. BRADLEY: You time has expired.

MON YUCK YU: That are working to connect with the system, and we cannot properly address

vaccine questions. CBOs like AMPHS have been at the forefront of vaccine education. Our community health workers offer interpretation to help community member navigate healthcare and financial assistance systems. We have created tablets with listen session in our community to create vaccination education materials. Every month, we're distributing thousands of pieces of literature through our canvassing and food distribution efforts which translated old materials, our old form to get people connected vaccine appointment and fielding 60 hours of calls every week to connect people to their appointments, but we are not funded to do this work through H&H and are asked to subcontract with a few funded organizations by Test and Trace which only include AP serving organizations to my knowledge who do not have an obligation to partner with any other groups. CBOs need to be funded through this work because we are needed to do this work in culturally and linguistically sensitive ways. This is not (inaudible), this is perpetual instructual healthcare racism, and our City and State needs to do better to send their voices of color and those who are most marginalized.

COMMITTEE COUNSEL HARBANI AHUJA: Thank you for your testimony. I'd like to now turn it back to Chair Rivera for any questions.

CHAIR RIVERA: Sure, if I could follow up on the comments about being subcontracted out. So, you just mentioned your one of the very few, to your knowledge organizations that really understands the community language and cultural. Have you received any funding since July 2020?

MON YUCK YU: So, we were not one of the contracted organizations under Test and Trace. When the list came out, we were given the list on the website and told that we could have an option to subcontract with one of these organizations. There were no obligations for any of those organizations on the list to subcontract with other smaller groups, and you know, there are many other groups like ours that are doing on the ground work that might not have the resources to go through convoluted application process that Test and Trace put out. So, again, these groups are now left out of funding opportunities. We have not been able to receive any funding directly through Test and Trace and we only have a small subcontract with one of the

organizations right now which funded our work through the end of November, but we've been continuing our work since, you know, since as long as I can remember, and we have not been funded at all.

CHAIR RIVERA: I thank you so much and I can also understand kind of like the awkward pressure that it is to subcontract when, I'm sure, you're all operating with very, very limited resources, and this is my last question for you, if you don't mind. You mentioned, I think you went to a vaccination site that really had no bi-lingual, tri-lingual staff and really none of the materials were translated either. Do you mind me asking what vaccination site was that? If you remember or what neighborhood? I think she has to be unmuted.

MON YUCK YU: That was a vaccination site in Sunset Park, in Brooklyn Army Terminal.

CHAIR RIVERA: Okay, I mean, I think I remember you saying that, and I just wanted to reiterate because I think we understand how ethnically diverse Sunset Park is, so, there should be some safe assumptions to be made by the City and it's unfortunate that they were not… (crosstalk).

MON YUCK YU: If I can just add, I'm sorry. If I could just add, you know, something that we heard about today at the site was that currently it seems like there may be interpreters at the site, but the only Spanish-speaking interpreter is a security guard, and it seems like earlier this week, we had a community member that could not communicate with somebody at the front, and they could not find them on the list, and were escorted out by the same security guard. We don't know rather or not this security guard spoke Spanish, but that's the exact type of racism that we're experiencing on the sites.

CHAIR RIVERA: Thank you for your time. Thank you to the panel for trying to help people who are experiencing domestic violence and intimate partner violence and for trying to help individuals seek primary care at the very least or even urgent care. I just want to thank this panel very, very much for being here and for your testimony. I'll turn it back to Committee Counsel.

COMMITTEE COUNSEL HARBANI AHUJA: Thank you, Chair. I'd like to ask if there are any other Council Member questions at this time. Seeing no hands, I'm going to thank this panel for their

testimony, and we'll be moving on to our next panel. In order, I will be calling on Anthony Feliciano, followed Andy Ospina. Anthony Feliciano, you may begin when you are ready.

ANTHONY FELICIANO: Good afternoon. Anthony Feliciano. I'm the Director of the Commission on the Public Health System, I'm also part of the People of Color Health Justice Campaign. I wanted to thank Council Member Rivera and the other Council Members here for the opportunity again to be here to speak about inequities that we're still seeing in COVID response, but also to thank the Councilwoman Rivera for being with us over the weekend on the exact same issue that all of us are talking about. I'm not going to reiterate every single thing our partners have done here, and we are honored to be working with them on many levels, but I would say this, a short story. CPHS and myself, more than 15 years ago, issues around language access when there was no Executive Order, when we're in real recollections around it, and I'll give you an example, we had a woman who had a son that had asthma. She was given a prescription that said steroids once a day. They had a janitor in the

hospital translate for her, the part of the drug, and she gave the child 11 doses. Why? Because once a day when you read it, is "once" in Spanish. That was a tragedy more than even and found that a lot of language access rules. I say this right now because it is insurmountable to ask a security guard or anyone who doesn't understand terminology to be interpreting to someone at a site. We have HIPAA laws, we have Federal dollars that are going to do this public work, and there are language access laws that are not being fully enforced or addressed. There is no reason why we cannot work with community-based organizations to identify people to volunteer to speak, to be trained by the City Department of Health to do language interpretation and translation. The other thing is, in the past, when signage was given in a hospital when it came to interpretation and translation services, they were in and behind the bathroom doors. They were hidden everywhere. We need to figure out where are this signage is posted and if they're being posted with multiple languages on one paper because it's confusing for people. They need to be separated for Spanish-speaking, for Chinese-speaking, for Korean and so on. The other

thing is that they're not working with CBOs to look even what they're writing and what their message is. For example, Arabic is so academically written that no one in community can understand it, and this is what we are hearing from many of our colleagues and advocates. So, we need on-site interpreters. We need on-site healthcare people that speak the language and look like the people as well, because we know about the emotional toll, and it can help out, but we don't need security guards because of HIPAA violations and we (inaudible) to be interpreted. Now, this is the City level work. We know that the State is also to be finger-pointed on many levels of position, very similarly. The large hubs are having the most problems because again, you're sacrificing what Hallie said, equity for efficiency. We need more that can work (inaudible) work together at the language access capacity that can help out. Then finally, on the Federal level, we need to think and have Council fight back on… (crosstalk).

SGT. BRADLEY: You time has expired.

ANTHONY FELICIANO: The pharmacies are having; they're not providing interpretations services. They only sometimes have the form, only in

English. The form says right on the top, that if you need to put your health insurance card and you need a health insurance card to get vaccinated. If I am a person of color, a person who is Latino who is reading this in Spanish, the first thing I think about, what is this? I thought this was free. I may even go away. So, even in what we're placing in the language on forms is important. The other thing is we have 200,000 indigenous people living in New York States, 50% live in New York City, and we have no address any of the language issues going with that, including everything else in these indigenous communities, and then finally, I think we need to address the fact of the otherness and safety of people of color coming to these sites. You know, particularly with the Asian hate that is going on, we need to make people feel safe, even standing on the lines to get care. Those things are important. So, we need interpreters to even say in their language, you're okay here, you're safe. There needs to be some compassionate way of doing things with these sites. The only way we can do that is through community-based organizations and workers and that we need to bring in those pharmacies that are no

providing what they need to do, and we cannot have an excuse that well, they're a separate entity getting funding and moving this along. Thank you.

COMMITTEE COUNSEL HARBANI AHUJA: Thank you for your testimony. I'd like to now welcome Andy Ospina to testify. You may begin when you are ready.

SGT. BRADLEY: Your time begins now.

ANDY OSPINA: Good afternoon. My name is Andy Ospina. I am the TGNCIQ Health Advocate at Make the Road New York. I'd like to thank the City Council and the Committee on Hospitals for giving us the opportunity to provide testimony today about language access services and equitable care at NYC hospitals during COVID-19. Make the Road New York is a non-profit community-based membership organization with over 24,000 low-income members dedicated to building the power of the immigrant and working-class communities to achieve dignity and justice through organizing policy intervention, transformative education and survival services. We are operating in five community centers, Brooklyn, Queens, Staten Island, Long Island, and Westchester. Low-income individuals, immigrants, people of color, and other vulnerable communities are dying of COVID-19 at high

rates in New York City. It is essential that government and public agencies be linguistically accessible, providing interpretation and translation services for the over 5 million individuals in New York State who are limited English proficient. New York City has made improvements in language access services over the years; however, our communities are still experiencing barriers to access in healthcare due to language access issues. Hospitals still sometimes rely on family members to translate or provide inadequate and inconsistent translations services when this could be dangerous and have life-threatening consequences as wrong translation and interpretation can lead to misunderstanding of the current health condition and care plan or even lead to misunderstand of the discharge plan, much like Anthony said about the incidence with the "once" and ones being misunderstood. Often times, there are delays in access in translation services at the hospital which slows down the admittance process or hinders the care received once hospitalized. Make the Road New York members have shared experiences of being ignored while trying to get attention of hospital staff because there was no one who spoke a

language other than English. Once of our members felt abandoned on an emergency room and had to call her daughter on the phone begging for help. She asked her daughter to call the hospital and request the hospital staff attend to her needs. Some of our members have reported not receiving translation or interpretation services at all and instead had hospital staff speak to them loudly and slowly as if this would increase their understanding of the English language. We know the value of our public hospitals for our people in our communities, yet mechanisms must continue to exist to ensure equitable and quality translation and interpretations services are being offered to the most vulnerable New Yorkers with limited English proficiency. So, during COVID, we saw how much our communities relied on Health and Hospitals for ongoing care, especially those individuals without insurance. At Make the Road, we believe that funding that necessary for Health and Hospitals as they continue to support the most vulnerable communities. Our communities are plagued by an ever-diminishing number of hospital beds, although there has been an increase in Teleservices offered. Our communities are unable to access these

services because of a lack of trust and a lack of adequate technology to access these newer availabilities. Wait times for access and care were long prior to COVID, and they continue to increase. May clinics that the community relies on for… (crosstalk).

SGT. BRADLEY: Time has expired.

ANDY OSPINA: STD and HIV testing among other services, are currently close due to COVID or have limited appointments available. This is increasing the demand for in-person services, thus inundating our hospital system. Community members are seeking services in the emergency room, which should be addressed with the primary care provider or specialist in the doctor's office or clinic. This inequitable approach is delaying thousands of low-income people of color from continual access to dire health services to treat conditions like diabetes and high pressure. Understand the needs for transgender, gender nonconforming, intersexual and the queer population is important to ensuring that they can access all the necessary testing and treatment required, especially Prevelin and TGNCIQ community is a lack of inclusive language which creates a greater

divide and another barrier to equitable access to care. Inclusive language across all healthcare setting and providers needs to be enforced in all public health sectors as part of the City's approach to equitable care. The continued need for mental health services has been exacerbated by COVID, yet few affordable options exist for folks who have limited English proficiency. This is especially true for low-income New Yorkers or immigrants who do not have access to health insurance because of their immigration status. As for our TGNCIQ folks, they experience mental health issues at a rate two to three times higher than non TGNCIQ individuals. So, as a proper city response to equitable care, Make the Road recommends the following. An expansion of Centers of Excellence or H&H outpatient clinics as an option for integrating comprehensive care communities that were hardest hit by the pandemic, sustain and expanded funding for programs like NYC Care to connect uninsured individuals to free or low-cost health services, CBOs should receive sustained funding to do outreach and education programs such as NYC Care as well as for COVID and the vaccine outreach and education, continued funding for

community health worker projects where CHWs are based at CBOs and are working close partnership with H&H healthcare facilities. CHWs can serve as a bridge between the healthcare systems and the community insuring that community members access the healthcare services they need, and expand TGNCIQ healthcare liaison program, funding for staff at city hospitals can act as case managers and advocates for TGNCIQ patients to help enforce people's rights within the healthcare system to make the best possible healthcare outcomes. I appreciate the Committee's time today, and we at Make the Road thank you for your work on this crucial topic. Thank you.

COMMITTEE COUNSEL HARBANI AHUJA: Thank you for your testimony. I am now going to turn it to Chair Rivera for any questions.

CHAIR RIVERA: I just, you know, you both mentioned, you know, a bunch of issues they tried to cover with Greater New York as well as Health and Hospitals, so the expansion of the Centers of Excellence, do you feel, you know, so, I think we all know for the past 20 years or so, that there have been a closure of hospitals in communities, not necessarily with people who need the care, but people

who have not been able to pay, right, so you know, further marginalizing our communities who historically have not had the same access to medical services as our more privileged communities. Do you think the expanding, or I guess, including more Centers of Excellence, what is kind the vision there? Is it in certain communities that you feel just are underserved medically? I guess this question is for Andy.

ANDY OSPINA: Yeah, I believe if we were talking in terms of steps, that would definitely be one of the first steps for sure to ensure that those communities are being taken care of where they have been left behind.

CHAIR RIVERA: I agree, I agree, and I appreciate you mentioning, you know, our transgender, nonconforming, intersexual community. I think, you know, some of the competency, the appropriateness there is certain a work in progress, so any sort of recommendations that your organization might have that, you know, I'd be happy to advocate and convey with Health and Hospitals specifically, I think, is going to be really, really important. I think it can, you know, these services can be, you know,

filtered down to just a couple centers citywide when you know, this is such an incredibly important part of all of our communities, you know, and this Anthony, I guess for you, you know, you mentioned hospital language coordinators or someone at these sites who supposed to make sure that there's interpretation. Can you just maybe talk a little bit about what you mentioned for a second there?

ANTHONY FELICIANO: Yes. Supposedly, every site, at least (inaudible) there's supposed to be someone that's coordinating if there are necessary issues around language, the interpretation, translation, including for hard-of-hearing. I do not know if it's at every site, so that's one issue. I don't know if it's at the site where the coordination is actually falling apart. Those things are critically important to look at. I just want to add to what Andy said, I think the centers, we have things already in place, the World Trade Center Clinic, there's some modeling there that we can think about around the Center of Excellence, so the things that they didn't do that should be particularly important, and then if you look at Mt. Sinai's World Trade Center and Occupational Health, they don't get

properly funded from even Mt. Sinai, so we have things existing in place that can be built upon and our Center of Excellence should be thought about with community-based organizations, and I want to tell you, Councilwoman, that this, I give it the Mayor's is putting out for a Pandemic Center, is a huge problem for me because the segregation and disconnect from community and we're having these Centers of Excellence, I don't understand what the model is for a Pandemic Center. How is that (inaudible) NYU who are perpetrators of racism (inaudible), and it is not even in none of our communities. It is in a much more identified and much more affluent community, so why put Pandemic Center there who will have the role of a City Department of Health when someone like Make the Road and others now will have to go to them too to get funding. This fragmenting and this is totally racist in my point of view in terms of investment and in terms of policy.

CHAIR RIVERA: Thank you. I really appreciate your comments. I think the real point of this hearing was to discuss how we're supposed to be more community minded, and so with all the organizations that have testified today already doing

the work on the ground, and not really feeling supported ever, especially throughout the pandemic, I would say, I think that's been a real problem and a dis-service to so many of our friends, our family, our constituents, our neighbors. So, I want to thank you both for taking the time to testify and I really, really appreciate your words, and I'll turn it back over to Committee Counsel.

COMMITTEE COUNSEL HARBANI AHUJA: Thank you, Chair. I'd like to ask if there are any other Council Member questions at this time? Seeing no hands, we've concluded, uhm, I'd like to thank this panel for their testimony. We've now concluded public testimony. If we have inadvertently missed anyone that is registered to testify today and has yet to be called, please use the Zoom raise hand function now, and you will be called on in the order that your hand has been raised. Okay, I'm seeing no hands, so I'm going to turn it back to Chair Rivera for closing remarks.

CHAIR RIVERA: I want to thank the entire staff, the Committee, our Sergeant at Arms, everyone at the Council for really coordinating and helping us out to have this really important hearing today. I

think we've heard firsthand from people who are doing the work in our communities from Administration officials, I know what we urgently need is prioritization of language access at vaccine sites and in all outreach materials, clear documentation and data on how much vaccine supply is going to our communities of color, and it's clear that we need immediate funding to community-based organizations for vaccination education and outreach which is a model very similar to what we did for the 2020 census, and I know that we've all been trying our best and in many ways feel overwhelmed and still struggling to survive, but I think New York City's healthcare system really fell short for non-English speakers during COVID-19, and we have solutions on how to fix it, so we are most linguistic diversity in the world and I truly believe that our hospital services and public health outreach should reflect that. So, I want to thank everyone for their testimony and how we can take some of these concrete solutions and implement them immediately and of course, again, to everyone for being here and testifying. I guess with that, we will close out the hearing.

COMMITTEE COUNSEL HARBANI AHUJA: Thank you Chair. Take care everyone.

C E R T I F I C A T E

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

Date MAY 18, 2021