CITY COUNCIL
CITY OF NEW YORK

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TRANSCRIPT OF THE MINUTES

Of the

COMMITTEE MENTAL HEALTH,
DISABILITIES AND ADDICTION JOINTLY
WITH COMMITTEE ON HOSPITALS

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April 21, 2025
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HELD AT: COUNCIL CHAMBERS – CITY HALL

B E F O R E: Linda Lee, Chairperson of the Committee on Mental Health, Disabilities and Addiction

Mercedes Narcisse, Chairperson of the Committee on Hospitals

COUNCIL MEMBERS OF THE COMMITTEE ON MENTAL HEALTH, DISABILITIES AND ADDICTION:
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A P P E A R A N C E S

Christina Curry, Commissioner of the New York City Mayor's Office for People with Disabilities

Emily Sweet, General Counsel at the New York City Mayor’s Office for People with Disabilities

Julie Friesen, Deputy Commissioner of Administration at New York City Department of Health and Mental Hygiene

Ivelesse Mendez-Justiniano, Chief Diversity, Equity, and Inclusion Officer at New York City Health and Hospitals

Manny Saez, Vice President of Facilities at New York City Health and Hospitals

Evan Yankey, Advocacy Director for Brooklyn Center for Independence of the Disabled

Nina Shields, Pro Bono Scholar for the Disability Justice Program at New York Lawyers for the Public Interest

Andrew Santa Ana, Interim Co-Executive Director of the Asian American Federation

Sonyong Lee, Bilingual Counselor of the Korean American Family Service Center

Elinor LaTouche, Executive Director of the Epilepsy Institute

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

Chelsea Rose, Policy and Advocacy Manager at Care for the Homeless

Sharon Brown, Rose of Sharon Enterprises

Neil Kalish, United Ambulette Coalition

Mbacke Thiam, Housing and Health Community Organizer at Center for Independence of the Disabled in New York

Kathleen Collins, Board Member of Disabled in Action in Metropolitan New York

Miranda Stinson DeNovo, Founder of Long COVID Safety Net

Melissa O'Brien, Medical Director of Psychiatric Services at Project Renewal

Christopher Leon Johnson, self

Avonne Parra, self

SERGEANT-AT-ARMS: Testing, testing. This is a sound check for the New York City Council Committee on Mental Health, Disabilities and Addiction joint with the Committee on Hospitals, recorded by Sergeant Ben Levy in the City Hall Chambers on April 21, 2025.

SERGEANT-AT-ARMS: Quiet down. Good afternoon, and welcome to today's New York City Council hearing from the Committee on Mental Health, Disabilities and Addiction jointly with the Committee on Hospitals.

At this time, I'd like to remind everyone to please silence their electronic devices, and at no point going forward is anyone to approach the dais.

If you'd like to sign up to testify in person, you can do so by filling out a form at the table in the back with the Sergeant-at-Arms, and if you have any questions throughout the hearing, please feel free to ask one of the Sergeants-at-Arms for assistance.

Chairs, we are ready to begin.

CO-CHAIRPERSON LEE: Thank you. [GAVEL] Good afternoon, everyone. My name is Council Member Linda Lee, Chair of Committee on Mental Health,

Disabilities and Addictions, and I want to thank Council Member Mercedes Narcisse, Chair on the Committee of Hospitals, for joining this hearing on evaluating access to healthcare for patients with disabilities.

Before I begin, I would like to recognize that we have been joined by the following Council Members, Council Member Louis, Rivera, and we also have Council Member Moya online.

And I'll just go right in. There are almost one million people in New York City living with disabilities, and more than half have a physical or mobility disability. These numbers are not abstract. They represent our neighbors, coworkers, family members, and constituents, people who deserve the same quality of care as anyone else. Unfortunately, we know that that is not the case. Studies show that adults with physical disabilities face persistent structural barriers to accessing healthcare, particularly primary and preventive care. Many medical facilities still lack accessible exam tables, mammography machines, I'm surprised I said that word correctly, and trained staff. Too often, this results in people with disabilities being

referred elsewhere, or worse, going without care altogether. The reality is that these barriers result in worse health outcomes for adults with disabilities, more chronic illness, more preventable hospitalizations, and tragically shorter lifespans. We also know that these disparities are not the result of individual failure, but of systemic gaps in how our healthcare system is designed. And when Chair Narcisse and I were going through the materials last week to prep, we wanted to be very clear, this is not placing blame on any one particular person, agency. We know that this is a very challenging issue that we want to try to start peeling the layers back of how we address a lot of these issues so that our disabled community and those that are most marginalized are actually getting the healthcare services that they need. Doctors and health professionals are doing critical work under immense pressure, but we can and must work together to ensure every New Yorker, regardless of ability, has equitable access to care. That starts with identifying where the system is falling short, and then taking action to make sure it is more inclusive, more responsive, and more just.

Today, we will hear from the Administration, advocates, and community members about services that are provided, barriers that adults with disabilities continue to face, and hopefully, solutions that can bring meaningful change. I look forward to this conversation and to working with all of you to build a healthcare system that truly serves everyone in our city.

In conclusion, I want to thank my Staff and the Committee Staff for their work on this hearing, as well as the Administration for being here, and members of the public who are here to testify. We look forward to hearing from each of you.

And with that, I will pass the mic to Chair Narcisse for her opening statement.

CO-CHAIRPERSON NARCISSE: Thank you, Chair. Good afternoon, everyone. I am Council Member Mercedes Narcisse, Chair of the Committee on Hospitals. I'd like to start by extending my thanks to Chair Lee and the Committee on Mental Health, Disabilities and Addiction for convening this hearing so that we can discuss the City's effort to improve accessibility for New Yorkers. And most importantly, thank you for the panelists that's here present.

The most recently available data indicates that 11 percent or 1 million New Yorkers live with a disability. Of those 1 million individuals, approximately 600,000 people experience ambulatory or mobility-related disabilities. Yet, many of New York City's hospital facilities were built before the passage of the American Disabilities Act and do not meet current accessibility standards. This means there are 600,000 New Yorkers who may inadvertently face obstacles in receiving the healthcare they need and they deserve. Like my Colleagues just said, we're not pointing fingers. We're just trying to make sure the people that need the help they deserve can get it. Even in facilities with updated infrastructures, patients often face inaccessibility exam tables, signages, and diagnostic equipment. Moreover, studies show that inaccessibility of healthcare provider facilities causes worse health outcomes for patients with disabilities. As a registered nurse, I know firsthand that accessibility, particularly in medical spaces, is absolutely necessary for maintaining the health of our community members living with a disability and the collective health of our city. While we still

have much to do, we are encouraged by the changes we have seen in healthcare spaces across the city. There are several renovation projects taking place as we speak, and we look forward to hearing from the Administration today about their progress. This Committee and this Council are committed to ensuring that no person is excluded from receiving appropriate medical care due to their disability. We'll continue to invest in our healthcare facilities and work with H and H, DOHMH, and MOPD to eliminate barriers for individuals with disabilities and seek to provide a credible medical care for all New Yorkers across our city.

Before we begin, I'd like to thank the Committee Staff, Senior Legislative Counsel Rie Ogasawara and Policy Analyst Josh Newman for their hard work in preparing for this hearing. I also would like to thank my Staff, Chief-of-Staff Saye Joseph, Deputy Chief Frank Shea, and Stephanie Laine, my scheduler, and of course, Irina Khlevner, the Director of Constituent Services, for their hard work as we continue to serve the City Council and our constituents.

Before I rest, I want to say, rest in peace, the Pope Francis, and all my Roman Catholic brothers and sisters, you have an angel above. Thank you. Now, I'll turn it over to Chair Lee.

CO-CHAIRPERSON LEE: Great. Thank you. Before I pass the mic over to our Counsel, just wanted to recognize we've also been joined by Council Member Marmorato.

And now we'll pass the mic to Committee Counsel to administer the oath.

COMMITTEE COUNSEL: Now, in accordance with the rules of the Council, I will administer the affirmation to the witnesses from the Mayoral Administration. Please raise your right hand.

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 questions?

ADMINISTRATION: (INAUDIBLE)

COMMITTEE COUNSEL: Thank you. Prior to delivering your testimony, please state your name and title for the record, and you may begin when ready.

COMMISSIONER CURRY: Good afternoon. I am Commissioner Christina Curry, Mayor's Office for

People with Disabilities. So good afternoon, Chair Narcisse, Chair Lee, and Members of the Committee on Hospitals and Committee on Mental Health, Disabilities and Addiction. Thank you for holding this important hearing. It would be nice if I put my glasses on, right? I am joined by Emily Sweet, General Counsel at MOPD, as well as from the Department of Health and Mental Hygiene, DOHMH, Julie Friesen, Deputy Commissioner of Administration. From Health and Hospitals, H and H, we have Ivelesse Mendez-Justiniano, Chief Diversity, Equity, and Inclusion Officer, and Manny Saez, Vice President of Facilities.

I come to this work not only as a public servant, but also as a member of the disability community. At MOPD, our vision is for all City programs and services, including healthcare, to be accessible and equitable for the nearly one million New Yorkers living with disabilities. We know that for many in our community, accessing healthcare remains a challenge. These challenges range from physically inaccessible exam rooms and diagnostic equipment to communication barriers and a lack of culturally competent care. We appreciate that our

City partners at Health and Hospitals and the Department of Health and Mental Hygiene are actively engaging on these issues. We have seen meaningful steps to address facility access, integrate ASL interpretation into appointments, and expand on digital accessibility for telehealth platforms, and develop disability awareness training, all of which are still in progress. We also recognize that the lived experience of many New Yorkers with disabilities reveal where the gaps remain. They point to a broader need for sustained attention and systemic improvement. MOPD stands ready to support our agency partners in advancing solutions, whether through technical assistance or ongoing trainings. We are committed to serving as a bridge between government systems and the disability community, ensuring that people with disabilities are not only included in conversations about healthcare, but centered in how we design and deliver care across the city.

Let me close with a reminder of a powerful motto from the disability community, nothing about us without us. Thank you again for your leadership on this important issue. On behalf of

myself and my colleagues from NYC Health and Hospitals and the Department of Health and Mental Hygiene, we welcome your questions and look forward to our continued partnership. Thank you.

CO-CHAIRPERSON LEE: Thank you so much, Commissioner Curry. We've also been joined by Council Members Abreu and Botcher.

And I know, Commissioner Curry, you and I have had many conversations around this topic, and I so thank you for all your advocacy and work around this important issue. So let me go ahead and just start off with a few questions and then I'll hand it off because I know Council Member Louis has to leave soon, so I'll hand it off to her after that.

So how can we at the Council and other government entities help increase and facilitate access to adequate and quality healthcare for adults with physical disabilities in New York City? I know that's a very loaded question.

COMMISSIONER CURRY: Well, fortunately I have General Counsel with me, Emily Sweet.

GENERAL COUNSEL SWEET: So the question is, I'm sorry, could you repeat the question?

CO-CHAIRPERSON LEE: Just how we on the Council as well as other government entities can help increase and facilitate access to adequate and quality healthcare, especially with those with physical disabilities in New York City.

GENERAL COUNSEL SWEET: So what the Council could do, I mean, it's a very loaded question, I would say so I'm not at liberty to request specific legislation so I think having a hearing like this at this time is a great first step so I think you're on the right track and doing the right thing. So, collecting information via forums such as this is a great start.

CO-CHAIRPERSON LEE: And I guess we'll go more into the weeds in a little bit. Because I'm more interested, and I think Chair Narcisse also is interested in what some of the biggest barriers are. We know that, for example, some of the equipment that is needed is very expensive so a lot of the physicians and doctors opt not to sometimes see folks that have disabilities because it is so costly for them, but that's more on a private practice side perhaps and in smaller clinics. But just off the bat in terms of, I don't know if this is a question also

more for anyone on the panel, but just how we can, what some of the biggest barriers have been in the hospital settings at H and H?

GENERAL COUNSEL SWEET: H and H, would you like to speak to them?

VICE PRESIDENT SAEZ: Hi. Good afternoon. Manny Saez, Vice President of Facilities for H and H.

The biggest barriers that we have faced is being able to not only handle our new construction and all of our new renovations, but also being able to, and we've done a very good job of bringing this up to speed, is providing all of the retrofitting that we've done because our hospitals have been so vintage, right, that we've been able to bring a lot of our spaces up to code as we follow code regularly to CMS, it's a federal agency, the State Department of Health, and other regulatory agencies that we abide by.

CO-CHAIRPERSON LEE: Okay. So, that's definitely going to be a topic I know that Chair Narcisse is going to bring up later, more in detail.

So going back, sorry, to MOPD, can you please provide an update on the work that's being done by digital inclusion officers across City

agencies? How has that been going? How do officers monitor materials for accessibility? And what is the process for someone to submit a concern if a document or website is not accessible?

COMMISSIONER CURRY: Okay. So, let's give you an update on what we call the DIO program, Digital Inclusion Officer. Ah, you couldn't hear me.

CO-CHAIRPERSON LEE: The irony.

COMMISSIONER CURRY: No, welcome to my world. So, let's try this again. We're going to give you our updates on the Digital Inclusion Officer Program, otherwise known as DIO. And the DIO acts as an agency digital accessibility advocate so that person is responsible for checking all of the access that, as per law, someone would look into, be it their website, etc. The programs right now is a voluntary program. There are 41 agencies that have a designated DIO to date as compared to the fact that there are more than 65 agencies that have posted their five-year plan. Most of the 41 DIOs have completed MOPD's suite of trainings. Some of the ones who were designated more recently have not. Each DIO is currently working on completing an audit of one of their agency's websites and putting together a

limited inventory of their agency's digital assets. So how do we monitor materials? Each agency's process is different based on their size and needs. Some agencies, such as DOHMH, have put in place a policy requiring an accessibility review of all documents prior to posting and distributing. Since the DIO program began several months ago, most agencies are currently working on figuring it out, how to make this work. As part of the DIO role, they should be checking a sample of documents for accessibility. This informs them of the areas of need so they can address it through training. Also, you want to know the process for submitting a complaint about digital accessibility. Substantially, all agencies, regardless of whether they have a DIO, have website accessibility statements on their website that includes information about how to report an issue with the accessibility of content on the site. Most agencies have a website have opted to include the City's website accessibility feedback form in their website accessibility statements. I just want to say one thing. This is a huge program. The fact that we have, it's a voluntary program, and we have 40 agencies thus far involved, that's a good thing, and

it's a testament to our work and our collaborative efforts with our colleagues sitting at this table here.

CO-CHAIRPERSON LEE: Definitely agree on that. If someone is on the website and wants to make a complaint, do they usually typically go through each City agency? Does each agency on their own website have the ability? Is it MOPD or is it DOHMH, I just want to clarify that that sort of is in charge of keeping those other City agency websites accountable and making sure that they upgrade or improve their websites.

GENERAL COUNSEL SWEET: Okay. So, that's a multi-part question. I'll try to answer each part. So I think the first part was?

CO-CHAIRPERSON LEE: Right, so if I'm from the public, I'm on the website and have a complaint, yeah.

GENERAL COUNSEL SWEET: Yeah. So, substantially all agencies should have a website accessibility statement, and I believe almost substantially all do. So, they include, most of them include the website accessibility feedback form there. There's also Office of Technology and

Innovation, if it's a City-hosted website, there's also something that's just there as a matter of course, a little wheelchair symbol on the bottom of the page, the accessibility symbol, and that leads also to the City accessibility, website accessibility, a citywide website accessibility statement. So, if it's a City-hosted website, then it will have, it might be a little harder to find or easier to find depending on your opinion, but there is a way on all City-hosted websites to do that.

CO-CHAIRPERSON LEE: And then ultimately, which agency is in charge of overseeing that each of these websites are compliant or that they're up to whatever the regulations are? And the reason why I ask that is because if it is MOPD, we all know that they have a super, super tiny, tiny budget. So my, she's laughing because she knows, we've talked about this before. It is literally, I think, one of the smallest budgets that I've seen at least in the City compared to different City agencies. I think at this point, it's around 400,000. And I think that if, I'm hoping that that does not fall on you guys, but if it does, we need to make sure that you have the resources to be able to oversee the compliance of a

lot of these websites so I just wanted to hear from you about that.

GENERAL COUNSEL SWEET: So, the Office of Technology and Innovation creates an accessible template. And I can't speak in detail about this, but in general, they create what should be an accessible template for, and I don't remember the name of it, for all City agency websites who use that template. But agencies are responsible for their own content that they post on that website. So that's what the DIO program is about, is making sure that the content that's posted on the website and any changes that someone might make, right, that the website is still going to be accessible and the content there is going to be accessible. So, OTI is giving the tools and then the individual agencies are responsible for making sure that the content is accessible.

CO-CHAIRPERSON LEE: Okay. And are they the ones also that are holding agencies accountable if they're not in compliance?

GENERAL COUNSEL SWEET: Is OTI?

CO-CHAIRPERSON LEE: Yes.

GENERAL COUNSEL SWEET: I think that's a question for OTI.

CO-CHAIRPERSON LEE: Okay.

GENERAL COUNSEL SWEET: Yeah.

CO-CHAIRPERSON LEE: Basically, I guess what I'm trying to get at is I just want to know which agency is in charge of overseeing everything and in, you know, keeping folks accountable.

GENERAL COUNSEL SWEET: Right. It’s not MOPD.

CO-CHAIRPERSON LEE: Okay.

GENERAL COUNSEL SWEET: Yeah.

CO-CHAIRPERSON LEE: Good to know. Okay. So, hopefully we'll figure that out. If you could get back to us on that though, that would be great.

GENERAL COUNSEL SWEET: Sure.

CO-CHAIRPERSON LEE: If you have the answer.

Okay, so moving on to the next question. Are housing providers and developers required to take MOPD's trainings on barrier-free construction and ADA compliance?

GENERAL COUNSEL SWEET: Okay. Oh, the question was whether housing providers.

CO-CHAIRPERSON LEE: Providers, yes.

GENERAL COUNSEL SWEET: Okay.

CO-CHAIRPERSON LEE: And developers are required.

GENERAL COUNSEL SWEET: And developers, okay.

COMMISSIONER CURRY: Okay. So, we currently do not have any trainings geared towards building developers. We can tell you what we provide, and that would be high-level digital and physical accessibility trainings, such as what we've provided for DOHMH.

ASL INTERPRETER: Did you hear me say DOHMH? Okay, yeah.

COMMISSIONER CURRY: Accessibility Liaison Committee. We have live in-person, or virtual disability etiquette and awareness trainings. And in addition to that, one second. We also provide deaf-specific disability etiquette trainings, but that doesn't really pertain to what you just asked about the building developers.

CO-CHAIRPERSON LEE: Okay. And do you all have a partnership or interagency group that you meet with regularly, for example, with Department of Buildings, as well as, I could imagine, Department for the Aging and other City agencies, where you can

go through some of the issues? Because I would imagine on a lot of the buildings, given how old they are, they may not be compliant. Some of them are grandfathered, which means they don't have to comply. So, I'm just curious to know if there is sort of an ongoing record-keeping and tracking of how to handle some of those building developers that need to address some of these issues.

COMMISSIONER CURRY: Okay. Yes, we have the Code Revision Committee, but in addition, we do talk. We have other agencies that we meet with. You mentioned Department of Aging. We do talk regularly with members from DOHMH and from H and H as well, in addition to a lot of other City agencies.

CO-CHAIRPERSON LEE: Okay. So in actually, in MOPD's 2024 report, we saw that MOPD conducted 24 site assessments to facilitate ADA compliance and issued approximately 40 ADA code recommendations. Are site assessments done on existing buildings or are they done for current construction projects?

COMMISSIONER CURRY: Okay. So, the site visits mentioned in MOPD's year-end press release were mostly to assess venues that were being considered for City-hosted events.

CO-CHAIRPERSON LEE: Okay.

COMMISSIONER CURRY: So for example, we visited many of the sites that were being considered for the series of hiring halls that the City hosted in 2024 and provided feedback as to whether the site was appropriate from an accessibility perspective and guidance as to what additional accessibility features, such as materials in alternative formats and additional signage should be put in place for the day of the event.

CO-CHAIRPERSON LEE: Got it. Okay. So not necessarily for residential buildings per se or for assessing that piece of it, correct?

COMMISSIONER CURRY: That is correct.

CO-CHAIRPERSON LEE: Okay. And then is there some partnership between MOPD and DOB when it comes to, let's just say I live in a building where the landlord is not being helpful if I need ADA accessible services, how does that then go through the chain and up the ladder in partnership with DOB as well as MOPD?

GENERAL COUNSEL SWEET: So, when MOPD receives a complaint from a constituent like that,

depending on the nature of the complaint, we would likely refer it to either CCHR or to DOB.

CO-CHAIRPERSON LEE: And then depending on what the finding is of that case, if let's just say they find out that the building does need to in fact be in compliance, then how does the City go through that process of ensuring that they're complying?

GENERAL COUNSEL SWEET: So MOPD would not be involved in that aspect once the case is referred out.

CO-CHAIRPERSON LEE: Let me ask a slightly different question. Should they be part of that process or do you think that you should have input in that? And the reason why I ask that is because I oftentimes feel that your Department should probably be consulted more often in a lot of these decisions and are often not at the table so that's why I'm just trying to figure out if perhaps there is a way where we can figure out an interagency partnership there.

GENERAL COUNSEL SWEET: I think that's something we could take under advisement and discuss further.

CO-CHAIRPERSON LEE: Not to give you more work, Commissioner Curry, but I feel like you have a

lot of value added so I just want to make sure that the voices of the disabilities community is part of that process because oftentimes with a lot of decisions we make at the City, we often say, oh, okay, if they had been brought to the table in the beginning, initially from the start, then we could have avoided a lot of things having to be redone. So, with that same mindset and vein, I feel like oftentimes MOPD should be at the table having a lot of these conversations with various different City agencies so I just wanted to put that on record.

Let me pause there and actually, oh, we've also been joined by, I was going to say Commissioner Cabán, sorry, Council Member Cabán, because I'm thinking Commissioner Curry, sorry. But yes, we've been joined by Council Member Cabán and then I'll pass it off to Council Member Louis.

COUNCIL MEMBER LOUIS: Thank you, Chair Lee and Chair Narcisse, and thank you all for being here today.

I just have two quick questions. Awareness and access to disability service facilitators. Every agency is required to have a disability service facilitator, yet many constituents

remain unaware of this resource, especially when interacting with City agencies that do not actively promote or offer clear pathways for DSFs. What is MOPD doing to increase visibility and access to DSFs across all agencies and how can a person with disability who is having difficulty accessing or navigating City services receive support from a DSF without already knowing they exist? Thank you.

GENERAL COUNSEL SWEET: That's a great question. And we do try to mention the DSF program in our outreach or whenever we meet with the community in our quarterly community calls, we mention the DSF program and the webpage nyc.gov/DSF where the contact information for all DSFs is listed. But if there's something more we could be doing, that's definitely a good conversation we could have.

COUNCIL MEMBER LOUIS: Definitely a partnership with community boards because they have made a lot of complaints that a lot of constituents don't know where to go and how to navigate it so it would be great if your agencies can partner with local community boards citywide to provide them with the information to share with constituents.

GENERAL COUNSEL SWEET: It's a fantastic idea.

COUNCIL MEMBER LOUIS: All right. Thank you. Thank you, Chair Lee. Thank you, Chair Narcisse.

CO-CHAIRPERSON LEE: Awesome. Okay, and I'll hand it over to Chair Narcisse.

CO-CHAIRPERSON NARCISSE: Thank you, Chair Lee.

My question toward H and H. How does H and H ensure access for those who may have disabilities relating to mobility?

VICE PRESIDENT SAEZ: Thank you, Council Member. H and H complies with all local, state, and federal requirements as I mentioned earlier. The public agency is covered by CMS and the New York State Department of Health. H and H has corridors that are large enough that do not restrict travel with ADA compliance. H and H hallways and handrails assist people where they need more stability when walking. And H and H restrooms and accommodations such as wider stalls and other accessories instead of restrooms are also ADA compliant. Access ramps are installed in all H and H buildings to facilitate movement throughout. Elevators are easily operated

and have ADA compliant controls. And there are also instances where we make accommodations for people who need additional support like lighting, ergonomic furniture, and automatic doors. Thank you.

CO-CHAIRPERSON NARCISSE: Thank you. What policies does H and H have to ensure plus size individuals can receive the healthcare that they deserve? I heard some part of it that you were saying so can you highlight a little more than that?

VICE PRESIDENT SAEZ: Sure. Thank you. H and H is committed to providing excellence in healthcare. Our providers work together to provide comprehensive personalized care to all New Yorkers. H and H can accommodate bariatric patients in large gantry CT scanners and other accommodations where that is required. Thank you.

CO-CHAIRPERSON NARCISSE: So very much, I can say that you, everything is accessible when it comes to disabled populations.

VICE PRESIDENT SAEZ: Well, we need that additional support, yes.

CO-CHAIRPERSON NARCISSE: How many section of 1557 complaints did H and H receive relating to disability discrimination in the last year? What is H

and H process for handling complaints and have any section of 1557 complaints gone to the U.S. Department of Health and Human Services?

CHIEF DIVERSITY OFFICER MENDEZ: Ivelesse Mendez, New York City Health and Hospitals. So we have had no documented complaints regarding disability discrimination in response to 1557. We do have a centralized grievance mechanism where we have each patient experience officer at every facility, which will conduct intake of any facilities and then they're also brought up to the Office of Diversity, Equity and Inclusion. To our knowledge, we have had no documented complaints that have been escalated to U.S. Department of Health and Human Services.

CO-CHAIRPERSON NARCISSE: I'm very proud to say I work at H and H.

Okay. Is H and H working to increase its compliance with standards put out by the Web Content Accessibility Guidelines? Can you explain in which ways you do and do not align with WCAG levels, AAA standards to which you rate yourself as partially compliant?

CHIEF DIVERSITY OFFICER MENDEZ: So, we are constantly improving our services and increasing

compliance with our standards. We are actually putting a plan together to strategize our approach to maintaining alignment with the WCAG standards and guidelines. We currently have, as our Commissioner Curry started earlier, we have our website accessibility statement which is available via our external internet. We also provide a mechanism web accessibility feedback form to make it easier for individuals to make any complaints, suggestions, or have any questions. We also discuss and raise awareness to help ensure our product designers, developers, content creators to continue to think about the need to focus on accessibility and WCAG guidelines. We currently work with Siteimprove which is a software that provides us with a real-time dashboard that allows us to have insight into where we stand in terms of compliance with the different levels of this WCAG.

CO-CHAIRPERSON NARCISSE: For my understanding, I just want to find out, have you received any complaints from the website by any chance?

CHIEF DIVERSITY OFFICER MENDEZ: Not to my knowledge, we have not.

CO-CHAIRPERSON NARCISSE: Not to your knowledge. Okay. How often do H and H clinicians, physicians, registered nurse, physician assistant, receive training on how to provide appropriate, respectful care for the patients with disabilities? Are those training developed or conducted in consultation with third-party experts on disabilities rights?

CHIEF DIVERSITY OFFICER MENDEZ: Thank you for that question. So all employees are trained upon hire through the system, New Employee Orientation. They receive training on providing culturally competent care. They also receive training on unconscious bias. In addition to that, this past year, we launched a Let's Talk Disabilities training where individuals attend the training are being taught all the differences between visible and invisible or non-visible challenges. They also receive disability ally pins so that patients can clearly identify them. Some of the trainings are conducted internally. Some are conducted in partnership with different organizations such as the Helen Keller Foundation. We have also put forth a training that is called the Low Vision Patient

Experience Simulation Training, which allows providers, nurses, clinicians, and any staff that wishes to participate on what it feels like to be someone with low vision. And here I brought another sample which we provide to participants which allows them to view the space as someone with low limited visual would have, and this allows them to be able to understand what a patient is feeling when they come in.

CO-CHAIRPERSON NARCISSE: Okay. So, I'm assuming you partner with Helen Keller Foundation.

CHIEF DIVERSITY OFFICER MENDEZ: Yes.

CO-CHAIRPERSON NARCISSE: Good. Are they real time braille, ASL, closed captioning, and CART services that are available for patient who are deaf or hard of hearing or who are blind to have limited visions? Are communication accommodation available for check-ins and other administrative communication in addition to their appointments with clinicians?

CHIEF DIVERSITY OFFICER MENDEZ: Absolutely. Thank you for that question. So, we have video remote interpretation available to patients. We also have onsite interpretation available to patients 24 hours, seven days a week. In addition to that,

patients that come in and they use MyChart. We also have high contrast features which allow individuals to access the content in an easier manner. In addition to that, we have, as you mentioned, we have CART services available to everyone in the system.

CO-CHAIRPERSON NARCISSE: In regards to the NYC H and H Coney Island Hospital, is the hospital operationalized yet or is construction still ongoing? If the construction is still ongoing, what is the expected timeline for completion?

VICE PRESIDENT SAEZ: Thank you, Council Member. The New York City Health and Hospital South Brooklyn Campus is fully operational and opened up in the fall of 2022. The hospital is fully in use and final commissioning work is commencing as well as punch list items to finalize all of the closeout procedures.

CO-CHAIRPERSON NARCISSE: What specific technology will be available at the new critical services tower at South Brooklyn, let me stop saying Coney Island, that are designed to improve accessibility for patients with mobility-related disabilities?

VICE PRESIDENT SAEZ: So, once again, we are fully compliant with all ADA requirements and the roof gate at Ginsburg Tower is a fully operational, modern, state-of-the-art facility that provides all the necessary accessibilities for folks that need that kind of support.

CO-CHAIRPERSON NARCISSE: Some of the question, I'm being specific because I want the answers because I don't want, when we continue the hearing, when we have people testifying in here different and you're already gone and then we still have to figure it out and send you a question. That's the reason I have to keep on asking you those questions.

Like I said, when we are talking, we are hoping that everything we ask you, you're going to be perfect on point with them because that's what we expected from H and H, especially public hospital in New York City. So, so far, I would say, thank you.

The accessibility in New York City report last released in 2021 highlights 2.5 million in City Council investment for capital improvement projects to renovate New York City H and H campuses at Sydenham, Morrisania, Cumberland, and Woodhall to

improve accessibility. Can you please describe the progress of the projects at these campuses and what specific renovation are being done to improve accessibility?

VICE PRESIDENT SAEZ: Thank you, Council Member. So for this particular question to be fully comprehensive, would just require just a little bit more time if I can be granted to do some more research and make sure that we have a fully comprehensive answer.

CO-CHAIRPERSON NARCISSE: Okay. How many of the H and H hospital location or Gotham Health Center campuses have facilities that have been specifically renovated or updated to implement accessibility function for patients who are wheelchair bound?

VICE PRESIDENT SAEZ: So, all of our H and H facilities have corridors that are large enough to not have any restricted travel. H and H complies with all local and federal requirements, once again. As a public agency under the federal guidelines of CMS and the State Department of Health, we work towards ensuring that all of our spaces meet ADA compliance in our Gotham sites. For example, East New York is

currently going under an ADA renovation for its restrooms.

CO-CHAIRPERSON NARCISSE: The reason I'm curious about those questions is because we have some old building that I know you took over so I just want to make sure those old building, are they accessible, wheelchair accessible? They have folks, because I know if we're doing that hearing, because we're hearing some so that's why I want to be specific on those questions from the old structures, are they accessible, fully accessible.

Are there any other ongoing renovation projects that are being considered for H and H facilities that we have not yet touched upon?

VICE PRESIDENT SAEZ: Just, as previously mentioned as an example, was East New York, that's working through its ADA compliance in its restrooms. And the design is complete for the facility, and we're working to procure construction services to complete the project. That's the one project that we're focusing on when it comes to Gotham Health in East New York.

CO-CHAIRPERSON NARCISSE: Okay. Does H and H provide any ways for patient with disability to

report if any, I think you had answered that. Okay. Does H and H have any ongoing policies that are aimed specifically at providing resources and career opportunities for employees with disabilities? And if so, have those initiatives received any feedback?

CHIEF DIVERSITY OFFICER MENDEZ: So, all employees have access to our Employee Resource Center which provides opportunities to training resources, benefits, EEO, as well as career opportunities. They are not isolated to disabled employees. However, they are available to all.

CO-CHAIRPERSON NARCISSE: Thank you. Do commercial insurance companies, Medicare, Medicaid, have different requirement for reimbursement for telehealth if the patient experiences a mobility-related disability?

CHIEF DIVERSITY OFFICER MENDEZ: Commercial insurance companies do not have different requirements for telehealth patients.

CO-CHAIRPERSON NARCISSE: That's a great concern. Because when it comes for H and H, maybe a little different, but Chair Lee and I were talking about the private facility, the clinic. So if they don't have that, how could they partner? I'm looking

at ways, maybe you can give me that idea because I'm looking at ways for those offices that near the hospital, if they can partner in a way, because we're putting a requirement over folks and then we're not taking in consideration the financial part burden on them and force them to close. And we need, especially in the Black and Brown communities, we need to make sure those doors are open to give access to healthcare that we promised in New York City so I don't know what kind of outreach that H and H can do within the community because I know one of the thing when I used to work for H and H, we used to go out there, we used to have partners to go in the facilities nearby to see how we can support each other. I don't know if you still, are you still doing that for H and H?

CHIEF DIVERSITY OFFICER MENDEZ: We do partner with community-based organizations. We have partnered with Disability Unite. We participated in the Disability Festival. We are happy to explore additional partnership opportunities.

CO-CHAIRPERSON NARCISSE: Because like say for a scale, someone wants to get on a scale, the doctor is probably not going to make an investment

for a very large scale, and then if the H and H or non-profit organization that you partner with, the person can go and weigh. I'm just looking for a different option because it's expensive. I used to have a DME and I know those equipment can be very expensive. And if the doctor only have one client, and now you know how difficult that would be for them to make that investment specifically for one patient that they want to provide care to. So I'm thinking, so in my way of thinking, I'm asking you, can you explore with me to see how we can make it effective to provide care with folks with disability in our communities.

CHIEF DIVERSITY OFFICER MENDEZ: Happy to partner and explore.

CO-CHAIRPERSON NARCISSE: Okay. When EMS and EMT personnel transfer custody of a patient from an ambulance to a hospital personal, what type of procedure does everyone follow to ensure that appropriate accommodation are made for individual with disabilities? Are there any training provided by this process, this specific process?

CHIEF DIVERSITY OFFICER MENDEZ: This would be an area that we would have to explore more

as this involves FDNY, and I do not have all the information.

CO-CHAIRPERSON NARCISSE: How often does HNH reviews their website and other digital resources to ensure that all materials are compliant with current accessibility standard? How often?

CHIEF DIVERSITY OFFICER MENDEZ: We review and update the policies based on changes in legislature as well as regulatory requirements. So, as these requirements come up, the hospital goes through all their review processes.

CO-CHAIRPERSON NARCISSE: So how often?

CHIEF DIVERSITY OFFICER MENDEZ: Usually on a yearly basis, on an annual basis, we'll review.

CO-CHAIRPERSON NARCISSE: Does H and H communicate with patients if they have knowledge of neighboring public transportation hubs or infrastructures is not accessible? For example, if the train subway station close to a hospital facility is undergoing renovation and their elevator is out of order, will H and H post that information publicly or communicate those barriers ahead of patient's appointment?

CHIEF DIVERSITY OFFICER MENDEZ: To my knowledge, we have not.

CO-CHAIRPERSON NARCISSE: Can we look into how, because like I always tell my folks that work for me, something that may not be important to you like (INAUDIBLE) and diapers, but for those folks that are using it is a lifesaving time for them. So can you look at that because people are complaining about like sometimes they come out of their way to go to an appointment and by the time they get close, they cannot actually go and get to the doctors because of limitation of access elevators or train stations and stuff like that?

Can healthcare providers bill for accommodation and accessibility services? Are they adequately reimbursed for providing qualified ASL interpreters? For example, are there caps on reimbursement for certain services? I think you said, no, they don't provide anything extra. You already answered that.

CHIEF DIVERSITY OFFICER MENDEZ: Yes.

CO-CHAIRPERSON NARCISSE: Which we should look into. What are the barriers to implementing accessible healthcare? It is primarily cost

straining. How can the Council work with H and H and the City to improve access to healthcare for patient with disabilities?

CHIEF DIVERSITY OFFICER MENDEZ: I think that when you talk about healthcare for patients with disabilities, a barrier as always are the resources, having the manpower to do it, having the funds to go out there, conduct the outreach. Those are two ways that we could receive assistance.

CO-CHAIRPERSON NARCISSE: Thank you. Has H and considered the impact of potential cuts to Medicaid and how this would impact the provision of services, especially for adults with disabilities?

CHIEF DIVERSITY OFFICER MENDEZ: So, we have considered the impacts. We have not seen any changes right now in terms of funding. However, we will continue to monitor to ensure based on our mission and our vision, we provide services to all and we will continue to provide services for all.

CO-CHAIRPERSON NARCISSE: Thank you. And I appreciate your time. So now I pass it on back to Chair Lee.

CO-CHAIRPERSON LEE: Okay. And I have questions for DOH and H and H, but I'll ask those

after we let our Members ask some questions. So, first up we have a Council Member Marmorato.

COUNCIL MEMBER MARMORATO: Thank you, Chair.

So, I just wanted to talk to the H and H people about radiology exams, and I know that you had mentioned usually when a plus size patient comes in, you have a larger gantry, but a lot of times the tables have weight limits. Can you kind of go over what your weight limits on a larger gantry table would be? Are you aware of it? Because I think it's usually about 350.

VICE PRESIDENT SAEZ: Yeah. What I can say is that the tables are meant to exceed the weight limits. Specificities on what exactly they are, I would have to do some research and just return that with a comprehensive.

COUNCIL MEMBER MARMORATO: Yeah. And it just doesn't stop at CT. I mean, if you want to do a breast biopsy, I know for a fact the table is 350. That's the max. You cannot raise the table up. There's bone density exams. There's a lot of different exams that plus size patients need to have as a medical necessity, and I just want to make sure

that Health and Hospitals is doing their job to make sure that this happens and that we can accommodate these patients.

What type of MRI units do you have at H and H because usually with a smaller bore, again, weight limits on the table, but you cannot fit a larger patient into the machine because you can put them at risk for skin burns and other issues.

VICE PRESIDENT SAEZ: We do have larger machines. To give you all the specificity, I'd really would just like to research that and give you a fully comprehensive answer on all the different types of MRIs that we have.

COUNCIL MEMBER MARMORATO: Okay. I would like to actually come for a site visit at my hospital in Jacoby Hospital, if that would be possible, if you can set that up, because I feel like it's important for us to treat these patients with dignity and respect, and just a CT, it just doesn't end there. There's so many different exams that they have to have and we have to make sure that they're being treated properly. Okay. All right. Well, thank you. Just want to.

CO-CHAIRPERSON LEE: Thank you, Council Member. And next we have Council Member Bottcher.

COUNCIL MEMBER BOTTCHER: Hi. How are you? The question for Commissioner Curry regarding Access-A-Ride, because one of the major barriers to accessing healthcare for people with disabilities, as we all know, is transportation, and Access-A-Ride, I've seen improvements with it since I've been involved in government. It has gotten better over the last 15 years and we hear that anecdotally, but we also continue to hear frustrations from our constituents about Access-A-Ride, missed appointments, lateness. What is your evaluation of Access-A-Ride as the Commissioner of the Mayor's Office for People with Disabilities? What are you hearing from your constituency and what efforts are you aware of that are underway to make it better?

COMMISSIONER CURRY: First, thank you for the question. That's a loaded, loaded question. I can say this, that MOPD has increased their involvement with the MTA to the point where I know where some of them live and I can track them down if I have to, but I didn't say that. Let's face it.

COUNCIL MEMBER BOTTCHER: We'll strike that from the record, kidding.

COMMISSIONER CURRY: Thank you. No, in all seriousness, wow. That is a question that involves a lot of different answers depending on the day who I've spoken to. I think you would be better served talking to MTA. What I can say is that MOPD is here to assist the community, listen to what they have to say about their complaints and their positive comments as well, and we take that back to the MTA to let them know what we are hearing, both good and bad, but we're also advising the constituency that they have to let all of you know what's going on, how they feel about it, be it negative, be it positive, but they have to be heard. And what we do know is a lot of times they, meaning the constituents, will let us know, and then that's it. You're right. Some improvements have occurred. I've been in the field for a very long time, and I will say it's gotten better, but.

COUNCIL MEMBER BOTTCHER: But just (TIMER CHIME) a little better, not a lot better. And we can, look, I think it's not personal against the folks at the MTA, the hardworking folks at the MTA, they are

in many respects inheriting the system that was there when they started working there, and they're limited with respect to funding and stuff. But I think there needs to be real talk with them about how this is going and we have to be very honest with them about what needs to improve. And if on a scale of 1 to 10, if they're like a 5, that's not acceptable, and we have to lay out what steps need to be taken to get them up to 10 out of 10.

COMMISSIONER CURRY: I definitely agree that more can be done. And yes, MOPD has several different avenues of staying in touch and meeting with the staff at MTA, not just about Access-A-Ride, but about the subway, about the buses, making sure that all of it is accessible for the community. And I have to say this, if you make it fully accessible for the community we serve, you make it accessible for your tourists, you make it accessible for parents with toddlers, you make it accessible for the older adults so it is our goal to continue working with them, MTA, on a regular basis to make sure that they understand where we're coming from, and then we also like to say when there are improvements, we like to put that out there for the community as well.

COUNCIL MEMBER BOTTCHER: Thank you.

CO-CHAIRPERSON LEE: Thank you. Yeah, I feel like we have actually had all day hearings on Access-A-Ride with our Transportation Committee so that could be an ongoing conversation for sure.

Okay. So, let me switch over to DOHMH because I don't want you, Deputy Commissioner, to feel left out so, you made the time to come here. So no, just this is going along with your five-year accessibility plan that came out in 2024, which identified several physical access issues that should be remedied so how many DOHMH facilities will need to undergo renovation projects to ensure that doors, elevators, restrooms, exam rooms and shared communal spaces are accessible for all patients, and is there an estimated timeline for some of these construction projects?

DEPUTY COMMISSIONER FRIESEN: Thank you for that question. I'm Julie Friesen, Deputy Commissioner Administration for the Health Department. I don't feel left out at all. Thank you for saying that. And thank you for your question.

So, as you probably know, the Health Department is a relatively small provider of clinical

services, healthcare services. We do have a handful of clinics and they are all accessible. They're all accessible and our offices are as well. Are they ADA compliant? No, they're not. They're all built prior to 1990. They don't meet those high standards, which are great. We wish they did. It's a work in progress. But we have made sure that all the entry points are accessible. And in our clinic buildings, it goes beyond the entry points. The waiting room areas have movable furniture. The exam tables in the sexual health clinics have power beds and are adjustable. The phlebotomy chairs are accessible. So, most of the restrooms are ADA compliant and we are renovating and retrofitting as we can. And we have more plans to do so in the future. We have wheelchair lifts and ramps as well.

CO-CHAIRPERSON LEE: Okay. And just out of curiosity, so not that funding is the only indicator, but I feel like depending how much money is in the budget, it is at least one indicator to show how the agency is prioritizing the needs. And so, could you, I don't know if you have the answer to this, but do you know what the total capital budget is for DOHMH facilities? And then what percentage of that is

actually being dedicated to upgrading a lot of the facilities to be ADA compliant?

DEPUTY COMMISSIONER FRIESEN: I will have to get back to you on the total number for our capital budget right now, but I can tell you, essentially, I would say all of it is allocated to making our buildings accessible because every time we renovate, we bring them up to standards, you know. We do have, and you'll see it in our update to our plan, I think, which is coming out in early May, but we have three new buildings that will be opening in 2026 and they will all be ADA compliant. One of them is a new public health lab on the campus of Harlem Hospital, and it's a large building. It's going to replace our existing building, which is across from Bellevue Hospital. It'll be state-of-the-art and fully accessible, and that project comprises the majority of our capital budget right now. And we also have a couple of projects. We have a couple of, you know, we do a lot of things. We have a couple of animal shelters that will be opening in 2026. A big one in the Bronx, a new one. And we're renovating the one in Brooklyn right now and it will be opening. They will be accessible as well. In this past couple

of years, we renovated the Staten Island Animal Shelter. It is now accessible. So, basically all of our capital projects have this in mind.

CO-CHAIRPERSON LEE: Okay, perfect. Good to know.

I don't know if you can speak for all the different DOHMH facilities, but for those that have not had accessible facility signage in entryways, restrooms, and elevators, have those signage issues been remedied? Do you know?

DEPUTY COMMISSIONER FRIESEN: Yes, I did look into that.

CO-CHAIRPERSON LEE: Okay, perfect.

DEPUTY COMMISSIONER FRIESEN: That's a work in progress. We have some Braille signage, mostly around elevators, inside and outside the elevators. Not all our buildings have that. And that's definitely a project for this next year. We're doing an assessment for that, and we plan to install more Braille signage.

CO-CHAIRPERSON LEE: Okay. If you could keep us updated on that, that would be amazing as well.

DEPUTY COMMISSIONER FRIESEN: Sure.

CO-CHAIRPERSON LEE: And have all DOHMH digital materials been updated to improve audiovisual accessibility for people who experience impaired vision or hearing? For example, ensuring that visual materials have been designed with accessibility in mind or ensuring that all images are accompanied by alternative descriptive text?

DEPUTY COMMISSIONER FRIESEN: Yes. So, we have a digital inclusion officer. And I know that our communications people have been working very diligently over this past year to remediate current PDFs that are posted on the agency's website to ensure accessibility. That's a work in progress, but it should be done over the next short while. And what remediation is, is maybe you know this, but I didn't. It includes ensuring proper document structure and tagging for compatibility with screen readers, using plain language, and ensuring alt text is provided for the images and visuals so that's being done now. And all new digital projects, including webpages, web tools, and surveys with external audiences for their use are being reviewed to ensure they're accessible.

CO-CHAIRPERSON LEE: Got it. Okay. And I have to say, because there was one, I think two

summers ago, I had an intern who was visually impaired in our office, and I have to say, that was one of the most incredible learning experiences for me personally, because I didn't realize also that even in our social media posts, if there's a document, if you attach PDFs versus an image file, that makes a huge difference when you're talking about that accessibility so I think even things like this would be great for us also on the Council to continue to get educated on, but it's good that you are all actually implementing this with your websites, which is great.

Can you please describe DOHMH's specific plans to, wait, actually let me skip that one, because you sort of answered that. Has DOHMH taken any specific action to improve workplace inclusion for people with disabilities, and how clear are processes for requesting accommodations?

DEPUTY COMMISSIONER FRIESEN: Yes. I'm actually very proud, if I could just speak about this for a minute, to say all of the work that we've been doing internally, because this started, and thank you for your leadership in this, both of you and all Members in this area, because even before the local

law passed, we actually created a position at the Health Department. We created a position, a Director of Disability Access and Justice, and this person, who is amazing, who comes from the community and is leading this effort, has done a lot of work to raise awareness and consciousness within the agency, within all of our staff. In the past year, she's done a lot of in-person training for hundreds of people. She has led workshops and educational events to raise awareness. And another idea she had and that we've launched is the creation of an employee resource group for employees with disabilities and their allies. Anyone can join. We had a kickoff meeting with the former Commissioner and Chief-of-Staff and myself. We were all there. It was very well attended. It's now grown to 135 people. And many of the people who are members have actually come forward and said, they have disabilities that are not apparent. And they didn't feel comfortable coming forward and indicating, sort of coming out with their disability before that, because they were worried about stigma, potential impacts to their career and so on so it's been a really transformative experience, I have to say, within the Health Department, this whole area of

work. I think people feel more included. Of course, we have more to do, but we're demonstrating a real support and encouragement for people with disabilities to come forward. They're doing ASL training. Some employees have volunteered to do this with other employees. That's become very popular. And these are folks who work across the agency in all the different areas of the Health Department. And I can say they bring that passion and that excitement and wanting to do something within their span of control in their program to sensitize other people in their areas. Just as you were talking about things you could learn and what you learned from having that intern, that's happening at the Health Department. And it really makes a difference because people will then bring that passion to whatever it is they're doing and want to make some changes.

CO-CHAIRPERSON LEE: Awesome. Thank you for sharing that.

What types of communication training opportunities have DOHMH employees received that were aimed at improving accessibility with external patients and partners?

DEPUTY COMMISSIONER FRIESEN: So, the training that we have for employees, there are a few things. First of all, all employees are mandated to take the DCAS Everybody Matters training, which is all about workplace inclusion in general, but DCAS has been, it's online training. Every City worker is supposed to take it. They track whether you've taken it or not. It's pretty good. It has several modules. So, everybody takes that. There is the MOPD's Disability Etiquette and Awareness training provided by MOPD, which is great. It's available for live training on request. We have had that at the Health Department. We've also shared the slides from that training. Our Director of Disability Access has shared those slides around our agency and encourage people to read them. And there is the live training, as I said, that our Disability Access Director provides as well.

CO-CHAIRPERSON LEE: Okay. And I'm assuming I can guess the answer to the next question, but do DOHMH's clinical staff receive any training on providing appropriate, respectful care to patients with disabilities? And how often are employees

required to take such trainings? I know you asked a similar question, Chair Narcisse.

DEPUTY COMMISSIONER FRIESEN: Yeah. So, our clinical staff take the required New York State training, which I believe includes some content around sensitivity and disability access.

CO-CHAIRPERSON LEE: Have you received, like, I'm curious to know what the feedback is of that training from a lot of the clinical staff. Is it something where it's just checking off a box, which I'm sure may be partly true for some folks, but how often is that training re-evaluated to make it engaging and to ensure that they're receiving the knowledge that they need?

DEPUTY COMMISSIONER FRIESEN: For the training for clinicians, New York State training? We'll have to look into that and get back to you.

CO-CHAIRPERSON LEE: Perfect. Thank you. Oh yeah, sorry, let me pass this to Chair Narcisse.

CO-CHAIRPERSON NARCISSE: Quickly, for the old building, I remember for the elevator, simply, I mean, things that can be simple for us, how do they access the elevators? Are we still using

braille in the front, or are we using other technology that I don't know of?

DEPUTY COMMISSIONER FRIESEN: The more modern, you mean? You know, I'm going to have to, I'll have to get back to you on that detail. I think there's some newer technology that's available for the elevators. Our new lab hasn't opened yet, and so I haven't actually used it myself.

CO-CHAIRPERSON NARCISSE: Yeah. Because you don't want someone that can be independent to have to depend on somebody else to wait how to access, even simple as elevator. And that goes for H and H too, what is going on there?

VICE PRESIDENT SAEZ: In our newer modernized elevators, we have the visuals and hearing components that are in the cabs to help assist.

CO-CHAIRPERSON NARCISSE: Okay. All right. Thank you, Chair. And the training, you said you didn't know how often it was being done as DOHMH, right?

DEPUTY COMMISSIONER FRIESEN: For the clinics.

CO-CHAIRPERSON NARCISSE: For the clinics.

DEPUTY COMMISSIONER FRIESEN: Yeah, the clinic staff, I'll have to get back to you.

CO-CHAIRPERSON NARCISSE: Okay. Thank you.

CO-CHAIRPERSON LEE: Okay. I think that's all the questions I have. I feel like there's a lot more to talk about related to this topic, but it encompasses a lot of other City agencies that are not present so we'll save that for another day, but I want to thank you all for being here and for your testimony and for sharing all your information with us, and that concludes the administration portion of our, oh, Commissioner Curry, did you want to say something?

COMMISSIONER CURRY: Yes. Thank you. I just had one comment, well, two. One, thank you for having us here today. This is a great dialogue so we can find out where the gaps are and how to assist.

But the second thing is, MOPD is here to educate. Always use any moment as a teachable moment. With that said, verbiage makes a big difference. We do not use the word impaired anymore. We do not use the phrase wheelchair-bound because they all have negative connotations. It's the same with, if you see the new symbol for the wheelchair, the person's

moving and not stagnant, it's the same thing. So, we see everything as a possible moment to educate and elevate knowledge about the community so I just wanted to take that time to say this as well.

CO-CHAIRPERSON NARCISSE: So what's the correction? Can you repeat how we supposed to say and say it properly?

COMMISSIONER CURRY: Thank you so much for asking that. So, what I would do is if someone said wheelchair-bound, I would say, oh, you mean the person who uses a wheelchair or that person's name because it's supposed to be focused on the individual. We don't say impaired because, sorry, that's a medical model and it implies that something is wrong with the individual so the verbiage has changed now to blind, low vision, deaf, hard of hearing. Because as we say in both in the community, there's nothing wrong with us, we just do it differently so that's why we no longer use a lot of the phrases that are still out there. We don't say handicapped, we say disabled because it gives a different connotation. It means we can, but we just do it differently. Thank you.

CO-CHAIRPERSON NARCISSE: Thank you for the lesson and thank you all the panels for being here. Thank you.

COMMISSIONER CURRY: Thank you.

CO-CHAIRPERSON LEE: Thank you. So, we're going to move into public testimony, but just giving a few minutes for us to transition so hang tight.

Okay. So, I'm now opening up the hearing for public testimony. I want to remind members of the public that this is a government proceeding and that decorum shall be observed at all times.

As such, members of the public shall remain silent at all times. The witness table is reserved for people who wish to testify. No video recording or photography is allowed from the witness table. Further, members of the public may not present audio or video recordings as testimony, but may submit transcripts of all such recordings to the Sergeant-at-Arms for the inclusion in the hearing record.

If you wish to speak at today's hearing, please fill out an appearance card with the Sergeant-at-Arms if you have not done so already and wait to be recognized. When recognized, you will have two

minutes to speak on the oversight topic, evaluating access to healthcare for patients with disabilities.

If you have a written statement or additional written testimony you wish to submit for the record, please provide a copy of that testimony to the Sergeant-at-Arms. You may also email written testimony to testimony@council.nyc.gov within 72 hours of this hearing. And believe me when I say our Staff, amazing Staff, read every single word, so you have up to 72 hours to submit that.

Okay. And the first panel that we have, and I apologize ahead of time if I'm mispronouncing anyone's name. Evan Yankey, Nina Shields, Andrew Santa Ana, oh, I know that name, and Sonyong Lee.

And feel free to go in whichever order and whenever you're ready to begin, just let us know. Do you want to start? Should we start on this side? Okay, perfect. Make sure your mic is on. Thank you.

EVAN YANKEY: Good afternoon. My name is Evan Yankey, Advocacy Director for Brooklyn Center for Independence of the Disabled, A disability-led independent living center promoting the rights of New Yorkers to live in the community since 1956. We are pleased this Committee is holding this hearing today

and giving the current state of healthcare access for patients with disabilities the consideration it deserves.

People with disabilities in our city's healthcare system face many barriers to equal access, support, and care. While some of them, including the MTA and the City shortfall in providing fully accessible transit, fall outside the immediate purview of your Committee, the Council as a whole can play a crucial role in advocating for them. We urge the Council to pass legislation that will require an independent accessibility review of New York City Health and Hospitals, including physical and communication barriers with additional requirements that set specific targets for elimination of those barriers. Currently, New Yorkers with disabilities, many of whom depend on New York City H and H, face physical barriers, including poorly accessible buildings, communications barriers, including sketchy availability of ASL interpretation, limited availability of plain language in easy-read formats, and inaccessible forms and websites, inflexible office procedures that don't take into account their disabilities, and poorly trained doctors, other

medical personnel, and other employees who discriminate against them because of their disabilities, in part because of inadequate training. None of these barriers are immutable. An independent review would start New York City Health and Hospitals on the way to real accessibility for disabled New Yorkers, especially if there are goals set to change the situation. As part of the independent review, or separately, require the City to hire an independent assessor to examine Health and Hospital facilities for diagnostic equipment. Additionally, pass legislation and funding designated for the training of New York City Health and Hospital staff in regular in-depth training led by disability organizations. And also, pass legislation to establish an office of the patient advocate, which would make certain that these reviews and changes receive appropriate follow-through. Whether or not the legislation moves forward, the Council itself should use this hearing to launch its own investigation of these barriers, including at private institutions.

Other priorities include opposing rules that would prevent people with disabilities or anyone else from using masks. Laws that criminalize masks

will subject people with disabilities to undue scrutiny and risk of negative interactions with police, first responders, and vigilante citizens opposed to mask wearing. Support smarter responses to mental health emergencies (TIMER CHIME) work to preserve remote options, and oppose the closure or reduction of services in safety net hospitals. We've sent our testimony to the Sergeant-at-Arms, and we're happy to answer any questions or respond afterwards. Thanks for this hearing.

CO-CHAIRPERSON LEE: Thank you. Actually, this is really comprehensive so I appreciate this, because you guys have a lot of really good suggestions here, so thank you.

Okay, next, go ahead.

NINA SHIELDS: Good afternoon, Chair Lee and Chair Narcisse. Thank you for the opportunity to testify. My name is Nina Shields. I'm a Pro Bono Scholar for the Disability Justice Program at New York Lawyers for the Public Interest.

As you've said, nearly one million New Yorkers have a disability, and anti-discrimination laws, including the ADA, require healthcare providers to ensure full and equal access to medical care for

people with disabilities. Despite these legal protections, individuals with all types of disabilities continue to face impediments to accessing healthcare. Adults with disabilities are almost twice as likely as others to report unmet healthcare needs due to the inaccessibility of medical offices. This lack of access leads to poorer health outcomes, including higher mortality rates and shorter life expectancies. For example, although women with disabilities have the same incident rates of breast cancer as women without disabilities, they're one third more likely to die from it due to delayed screening and treatment. The time for equal accessible healthcare in New York City is long overdue. Reaching that goal requires addressing the barriers that impede access to care. These include physical barriers, like doorways that are too narrow, exam rooms that are too small, as well as the lack of adapted equipment, like accessible scales, exam tables, and diagnostic machines. They also include communication barriers, like failure to provide a sign language interpreter or information in Braille or large print. This failure to accommodate results

in medication errors, misdiagnoses, problems during surgery and anesthesia, among others.

Lastly, patients with disabilities face attitudinal barriers from healthcare providers, such as bias and lack of training. This lack of disability competency degrades quality of care and leads to preventable inequities in health outcomes. To address these barriers, New York City healthcare facilities must implement changes to their physical structures and equipment, communication methods, and provider training. Our recommendations to the City Council include passing a resolution requiring New York City providers to comply with anti-discrimination laws to ensure equal access, and including funding in the budget to assist capital improvements at health and hospitals facilities to increase accessibility. We're happy to discuss any of these issues further with the Council. If you have any (TIMER CHIME) questions, we'll provide more in written testimony. Thank you.

CO-CHAIRPERSON LEE: Great, thank you.

ANDREW SANTA ANA: Okay. Shall I begin? All right. Thank you, Chair Lee, Chair Narcisse, and the Council Members of these important Committees for holding this hearing and allow us to testify. I am

Andrew Santa Ana, Interim Co-Executive Director of the Asian American Federation, where we proudly represent the collective voice of more than 70 member non-profits serving 1.5 million Asian New Yorkers. And I'll also submit more detailed testimony later.

We are here today to discuss the state of healthcare access for those living with disabilities. Under the new federal administration's evolving immigration policies, the mental health burden on Asian New Yorkers has exponentially increased, and especially for those struggling with mental health conditions and for those living with disabilities. This challenge is exacerbated by immigrants' growing reluctance to engage with formal systems of care as they are afraid to go to the hospital or the clinic with the fear of safety for them or their family members' immigration status. So, on top of community members with disabilities seeking care, there's additional levels of challenges. As we've heard today, community members are constantly weighing what they have to come out about, what puts them at risk, what opens them up for stigma, all in search for the possibility that when they speak their truth about their disability, that they can access services. So,

due to the chilling effect of these anti-immigrant policies being issued by the federal administration, there's going to be an over-reliance on Asian-serving CBOs to provide critical, responsive mental health services. This comes at a time when the majority of Asian-serving community-based organizations are experiencing significant federal funding cuts that impact their ability to provide social services. So, in short, our recommendations are, of course, to ensure that the mental health needs of Asian New Yorkers with disability are prioritized when mental health and social services resources are deployed in response to traumatic or violent incidents. We call on DOHMH and NYPD to make sure that their services are fully accessible linguistically and in appropriate other ways. We ask for compliance with Local Law 30. And, of course, when we're doing these things, having linguistically and culturally competent (TIMER CHIME) care readily available. I have more recommendations, but I will also open to the questions that you might have later on. Thank you so much.

CO-CHAIRPERSON LEE: Thank you.

SONYONG LEE: Shall I begin? Okay. Good afternoon, Chair Linda Lee and Chair Mercedes Narcisse and Members of the Committees. Thank you for the opportunity to testify. My name is Sonyong Lee, and I serve as the Bilingual Counselor of the Korean American Family Service Center, also known as KAFSC. We support immigrant survivors of gender-based violence through trauma-informed, culturally and linguistically accessible services, including 24-hour crisis response, counseling, housing, legal support, and economic empowerment programs. Every day we work with the survivors who are living with trauma-related disabilities, depression and anxiety, PTSD, and other long-term mental health challenges resulting from abuse, sexual violence, and chronic isolation. For immigrant survivors, especially those with limited English proficiency, accessing mental healthcare is already hard. For those with disabilities, it's nearly impossible. Culturally competent mental health providers who understand both trauma and disability are severely lacking. And for our clients, the fear of stigma, deportation, and being misunderstood often outweighs the hope of getting help. KAFSC is a proud member of the Asian American Mental Health Roundtable

convened by AAF. Together, we are calling on the City to, number one, prioritize mental health resources for disabled Asian New Yorkers who are survivors of violence. Number two, ensure that crisis response services are inclusive of people with disabilities and language needs. Number three, partner with a trusted community-based organization like ours who can reach and support these survivors (TIMER CHIME) effectively. We urge the City to invest in preventive community-based care that meets survivors where they are before their trauma becomes a lifetime barrier. Thank you for allowing us to speak on this critical issue. Thank you.

CO-CHAIRPERSON LEE: Thank you, everyone. Thanks for being here.

And next, we have Elinor LaTouche, Chelsea Rose, Neil Kalish, and Sharon Brown.

Okay, should we start from this side first this time?

ELINOR LATOUCHE: Hi. Can you hear me? Okay. On behalf of the many New Yorkers who live with or care about someone impacted by epilepsy, I want to thank you, Committee Chair Lee and Chair Narcisse, for this opportunity to speak to you about the mental

health needs of our constituents. My name is Elinor LaTouche, and I'm the Executive Director of the Epilepsy Institute. We've been doing business as the Epilepsy Foundation of Metropolitan New York for over 50 years. We're New York City's only specialized organization combining epilepsy education, awareness, and advocacy with individualized services such as psychological counseling, psychiatry, vocational supports.

Epilepsy is the fourth most common neurological disorder in the world, and 1 in 10 people will have a seizure in their lifetime. 30 percent of people living with epilepsy are treatment-resistant. At our Article 16 and 31 clinics, our clients report anxiety, isolation, and depression. Depression is the most frequent comorbidity of epilepsy. Our patients are often referred by their medical providers who recognize signs of mental illness. Sometimes that can be not showing up for appointments repeatedly. Our therapists use a variety of modalities, including trauma-informed treatment of depression in both individual and group support sessions as well as a self-management workshop. When the symptoms of epilepsy or significant side effects

from the medication make it difficult to leave the house, we pivot and provide remote services to support our patients to ensure continuity of service. We stand ready to support all New Yorkers through providing holistic supports to patients, families, and the communities. In Fiscal '24, we provided 6,200 therapeutic interventions in New York City. The most people we serve receive weekly service (TIMER CHIME) You have the rest.

CO-CHAIRPERSON LEE: It's okay. Oh, no, no. You can summarize it.

ELINOR LATOUCHE: Thank you. Thank you. Thank you. We do provide free seizure-first aid to people, New York City agencies and organizations, helping people understand what it looks like to have a seizure, how to respond. We're currently offering seizure-first aid to law enforcement and trying to ensure that when people are having a seizure, they're not mistakenly incarcerated for failure to respond. Thank you, and I appreciate your time.

CO-CHAIRPERSON LEE: Thank you so much. And we have the written copy, so don't worry. We will read everything.

CHELSEA ROSE: Good afternoon. My name is Chelsea Rose, and I'm the Policy and Advocacy Manager at Care for the Homeless. Thank you to the Members of the Committee for the opportunity to testify today. Care for the Homeless has been providing medical and behavioral health services exclusively to people experiencing homelessness in New York City for over 40 years. We operate 23 federally qualified health centers across all five boroughs, and they're co-located in shelters, soup kitchens, and drop-in centers. Nearly 40 percent of the over 12,000 patients we served last year are living with chronic health conditions that qualify as disabilities. Our model of care is built around accessibility, bringing care directly to where people are and removing barriers in a system that is often too complex to navigate, especially for people with co-occurring chronic conditions, psychiatric disabilities, and cognitive impairments.

Today I want to highlight three challenges. First, telemedicine, which has become a lifeline for many of our patients, particularly those who are older or managing chronic conditions. Last year, 28 percent of our visits were done via

telehealth, half of which were for behavioral health. Yet Medicaid only reimburses a fraction of the in-person rate. This places an enormous strain on our providers. We urge the Council to support payment parity at the State level so we can sustain this essential care model.

Second, an aging shelter population. We're seeing older adults with serious mental illness and/or dementia in shelters. Long-term care facilities often turn them away, leaving people stuck in shelters that aren't equipped to meet their needs. This leads to fragmented care and a significant strain on an already overburdened system.

Third, long-term psychiatric disability. Many of our clients have cycled through hospitals, shelters, and the streets for decades without successfully accessing coordinated care services or stable housing. Hospitals frequently discharge patients with known histories of homelessness and mental illness without a clear path to housing or continuing treatment. (TIMER CHIME) Shelters are left to fill the gap, but they are not equipped to manage complex psychiatric needs.

These are systemic issues that require systemic solutions. We need telehealth to be fully funded, long-term care options to be expanded, and real pathways to stability for people with chronic mental illness. Thank you for your time and your commitment to health and dignity of all New Yorkers.

CO-CHAIRPERSON LEE: Thank you.

SHARON BROWN: Hello. My name is Sharon Brown. Before I begin, remember Israel, release the hostages, let Yahweh's people go, defend Israel.

Okay. We are implementing the Bible teachings into the health system. We are going to be changing the way the mental health system and the health system is run. The access should be updated the way people get care. Instead of saying that people are mentally ill, they need to look into the physical disabilities that they do have. That has been largely ignored, and they have been diagnosed with all sorts of things that they don't even have. There have been many newspapers and things to say that many of the diagnoses, up to 50 percent or more, have been faulty, and the diagnoses are terminal, and there are faulty diagnoses. So, we need to change the mental health system. I was hired in, someone wants

me to teach their staff about mental health from a biblical perspective. It is a very well-known hospital, and we're going to change everything. We're putting the Bible back in school so that the mental health system that they have there will be removed from there, and the biblical teachings that we have in the churches where the children thrive and succeed, when we teach them things about the mind, how to think, how to live, they are thriving. When I was teaching in church, I was a president of a political organization, and the things that I was teaching the young people, I had people following the example that I set. There was a young lady who became president of her class. There were people thriving. There weren't people that were mentally ill. (TIMER CHIME) There was practically no one in the church that was mentally ill. So, we're going to institute biblical teachings for the health system.

CO-CHAIRPERSON LEE: Thank you. Thank you, Ms. Brown. Okay, next.

NEIL KALISH: Good afternoon, Chair Lee, Chair Narcisse, and Members of the Committee. I really appreciate the opportunity to be with you today. It's hard for me to do almost anything in two

minutes, but I'll try to skim through this succinctly, and you've got my written testimony as well. I represent the United Ambulette Coalition. My name is Neil Kalish, and Chair Lee, I have to say, already your office has been a tremendous help to us. I got word from John Wani (phonetic) a short while ago that we have 14 sign-ons to a letter that will go to DOT that could be tremendous help to us, but I believe we also need legislation so I'm seeking the City Council's support therein, and just briefly I'll get into the issue itself. But first a bit about Ambulette and what we do. We ensure access for New York City's most vulnerable population, the poor, originally I said handicapped, but I changed it to disabled, the elderly, Medicaid-enrolled, traveling to medically necessary care and treatment, such as dialysis. For the population we serve, transportation is a critical barrier or obstacle. It's not a luxury, it's a necessity. We go door-to-door. It is not a curb-to-curb service that we provide. We go up and down in non-elevator buildings, flights of steps, escorting patients, carrying wheelchair, again, I was going to say wheelchair-bound, but wheelchair clients residing in non-elevator buildings, down flights of

steps. During COVID we worked unfailingly. When the City was shut down, when buses, subways, taxis, livery were not working, we were out there to ensure that our clients could get to dialysis treatment and keeping New York City hospitals operational. Keep that in mind. But today, that same commitment that we've shown to New York City's most vulnerable residents is being punished. And what's happening specifically, and the issue that Chair Lee's office has been very helpful with, is MTA vehicles are now equipped with cameras, video cameras. As they pass our vehicles, when we're in a bus lane (TIMER CHIME) or double parked, and forgive me if I can just take a few more seconds here, they're videoing our vehicle. We may be dropping off a patient inside a facility. We may be double parked in a bus lane adjacent to a patient's residence. We all know that curbside parking is a rarity. We can't be circling around to find those spaces. And we're receiving tickets that are progressive in nature. 50 dollars first time a plate has hit an ambulette. Second time it's 100, 150, 200. Now we're up to 250. We're not big companies. We're not FedEx and UPS. We're independent providers, and we're getting tickets that amount to

thousands of dollars per month. This is an issue that needs to be fixed. The MTA Access-a-Ride program has an exemption. We've spoken to DOT about it. They said that MTA Access-a-Ride, that we're independent companies. Well, Access-a-Ride providers are also contracted with Access-a-Ride. They're independent companies. We need that same exemption. It's the same exemption that we received for congestion pricing based on the services that we provide. We need the exemption. It's great that a letter is going to DOT. I understand from Mr. Wani that legislation is also being worked on. We need that legislation as well. I appreciate your time, and I'm sorry I went a few minutes over.

CO-CHAIRPERSON LEE: No, no, it's totally fine. And thank you for bringing this issue to light because, as we all know, we're all in a city where we have bicyclists, cars, and buses. I think even in Queens where I am, I've seen parts of Queens where you have the parking and then the bike lane, but then what ends up happening is because there's only one service road lane, I actually see the buses, which makes me nervous, going into the bike lanes and around because they're trying to get around the

double-parked cars but usually it's to your point because there are so few drop-off zones to allow for patients to have that ability to get dropped off so you raise a very good point, and it's trying to figure out a way that we're trying to make everything work so that they can actually get dropped off at their treatment centers and medical facilities.

NEIL KALISH: No. We truly appreciate your help, and there is more to be done, but I think we're off to a good start here.

CO-CHAIRPERSON LEE: Yeah. No, thank you.

NEIL KALISH: Thank you.

CO-CHAIRPERSON NARCISSE: I can understand that myself because it's important to drop those patients, and some of them cannot really walk long distance, and you have to make sure you can get them to their doorsteps.

NEIL KALISH: Thank you. My own company is taking hundreds of patients in and out of dialysis every day. These patients are exceptionally weak and frail following treatment. We need to be nearby their residence, nearby their facility as we take them out of the vehicle.

CO-CHAIRPERSON NARCISSE: Thank you. I appreciate your testimony.

CO-CHAIRPERSON LEE: Thank you all.

Okay, so we will now move to Zoom testimony. So please wait for your name to be called to testify and select unmute when prompted.

So, first up we have Mbacke Thiam, and then next followed by Kathleen Collins.

SERGEANT-AT-ARMS: You may begin.

CO-CHAIRPERSON LEE: Mbacke, are you there?

MBACKE THIAM: Yes, I'm here.

CO-CHAIRPERSON LEE: Oh, good. Yay. Okay, good to see you online.

MBACKE THIAM: Good to see you, too. Thank you. My name is Mbacke Thiam. I'm the Housing and Health Community Organizer at Center for Independence of the Disabled in New York. We advocate for people with disabilities in the five boroughs of New York City, and thank you for giving us the opportunity to talk about people with disabilities and on evaluating the current state of healthcare access for patients with disabilities.

Patients with disabilities have the right to equitable access to healthcare. This includes language assistance. If needed, patients should ask for ASL interpreting or CART communication access, real-time translation services, papers in bright, large print, etc. Also, healthcare workers should receive disability training that will educate them on ADA compliance and accessibility requirements. Patients with mobility issues encounter several barriers to accessing quality healthcare. Physical accessibility issues, lack for accessible medical equipment, etc. Including a consultant with a mobility disability to advise the operators of healthcare facilities may help reduce these mobility barriers. Insurance coverage can also present numerous challenges for patients with disabilities or chronic disease. Some insurance coverage charges are high for disabled people. Also, they may fail to cover emergency needs for the patients with disabilities. For example, one of our consumers who had issues with his wheelchair and his insurance did not cover wheelchair replacement (TIMER CHIME) or repair.

SERGEANT-AT-ARMS: Thank you. Your time expired.

MBACKE THIAM: Thank you, everyone, for giving us the opportunity to testify.

CO-CHAIRPERSON LEE: Great. Thank you.

And next we have Kathleen Collins and then followed by Miranda DeNovo.

SERGEANT-AT-ARMS: You may begin.

KATHLEEN COLLINS: Thank you. Good afternoon, and thank you for having this hearing. My name is Kathleen Collins. I'm a native New Yorker who is a congenital quadruple amputee who uses a wheelchair, and I'm a member of several disability organizations, including on the board of Disabled in Action in Metropolitan New York. I already submitted some written testimony, which I may also amend later, but I'd first of all like to thank Councilman Bottcher for bringing up the whole thing about Access-A-Ride and about transportation, and that is one of the things I was thinking this Committee could actually work on is about the fact that we experience higher stress in trying to get transportation to our medical appointments, especially with Access-A-Ride, and I've heard many times people missing their

appointments because of Access-A-Ride and that. And also the fact that when you make your appointment, you have to kind of guess estimate when your appointment will be done, and there's the stress of will I be reached before I have to leave this appointment. But I give you some solutions. One is the eHealth pilot program that the MTA has started, and that that should be expanded to more people, and the price right now is 4 dollars, which is not an economic hindrance for me, but it is for many of our people. So therefore, if we could bring it down to what everybody else has to pay for transportation, which is $2.90, and that the number of rides not be limited. Right now, the number of rides are limited so you have to determine which rides do I need to have real-time access to transportation versus Access-A-Ride. So that's another thing.

Also, I appreciate Councilwoman Louis' statement concerning about disability service facilitators and how you can't find that information. And even on these five-year accessibility programs, even the one for DOH, it's not in the accessibility plan. It's somewhere else on the website. It just says the email address, but it does not give a

telephone number. It does not (TIMER CHIME) give a relay number.

SERGEANT-AT-ARMS: Thank you. Your time expired.

CO-CHAIRPERSON LEE: You can go ahead and summarize. Sorry.

KATHLEEN COLLINS: Okay. Well, that's just another example. And just two other things I want to bring to your attention is, one, there is no grandfathering provision in the ADA. It doesn't allow grandfathering. I don't know if that's a myth that people believe, but it doesn't exist.

And just the other thing, in their plan, that they don't set forth any deadlines. And we know that in their plan they talk about a compliance assessment that was in 2019, but what happened with that? And we worry about when you don't have deadlines, such as in these plans, things just keep moving down the road and things never get done. So please, we need more of that. And who would we go to on the City Council about these different accessibility plans, about them coming up with a better response?

CO-CHAIRPERSON LEE: If you're talking about transportation specifically with Access-a-Ride, for example? No. Is that?

KATHLEEN COLLINS: It would be all the accessibility plans. They all seem to have used the same kind of format, and they don't give you deadlines. They don't give specifics on what they're doing and how they're going to do it. And even the one here with DOH, it talks about meeting a five-pound force requirement, but it's not five pounds force requirement. It's less than five pounds. And even with the ADA, the ADA is a minimum guideline. It's not a high standard. I mean, these are all things that people don't understand, and I think that's leading people down the wrong path.

CO-CHAIRPERSON LEE: So, yes, this is actually a relatively new law that was passed and put in place, and so the agencies, well, one of the places to go is the folks that are in charge of putting the report out with each agency so that's one place. But ultimately, MOPD is the one that is monitoring the five-year accessibility plans for all the agencies.

KATHLEEN COLLINS: And does one Committee of the Council deal with the MOPD?

CO-CHAIRPERSON LEE: Yeah, this Committee, yes.

KATHLEEN COLLINS: Oh, okay. So, I'll have to write a letter to you guys.

CO-CHAIRPERSON LEE: Yes, yes. No, if you want, we can have a follow-up conversation after this.

KATHLEEN COLLINS: I would really appreciate that.

CO-CHAIRPERSON LEE: Okay. Great.

Okay. And then next we have Miranda DeNovo followed by Melissa O'Brien.

SERGEANT-AT-ARMS: You may begin.

MIRANDA STINSON DENOVO: Hi. Good afternoon. My name is Miranda Stinson DeNovo, and I'm the Founder of Long COVID Safety Net, which advocates for people with long COVID and other infection-associated chronic illnesses, such as ME/CFS, to get better access to healthcare and social services.

I'm here today to testify about an overlooked issue that affects this growing population and many others, and that's communication access,

specifically how healthcare in New York City continues to be inaccessible for people who are unable to make phone calls, whether because of an auditory disability or a speech disability. For context on how I'm using these terms, auditory disabilities include being deaf or hard of hearing, but can also include auditory processing disorders. In my community of people with long COVID, a common and perhaps surprisingly disabling symptom is hyperacusis, or extreme sensitivity to sound, which can make holding a telephone call extremely painful, if not downright impossible. One person I have worked with has had such severe hyperacusis that she would sometimes experience seizure-like episodes and lose her ability to speak, leaving the person on the other end of the phone to inevitably hang up. Speech disabilities, of course, can come in a myriad of shapes and sizes. So, in the interest of time, I'm going to borrow the broad definition used by the advocacy of non-profit CommunicationFirst to encompass anyone who, quote, cannot rely on speech alone to be heard and understood. This can include people with developmental disabilities, including autism, brain injury and stroke survivors, people

with neuromuscular disorders like cerebral palsy or ALS, and more. In the context of long COVID, there are at least two common reasons why someone might have difficulty speaking. The first being cognitive symptoms that affect things like word recall and ability to structure a sentence, and the second being extreme fatigue and muscle weakness. Even if a person can muster the energy to speak a few words, at this level of severe illness, it will almost certainly trigger debilitating symptoms after the fact, a phenomenon known in the ME/CFS community as post-exertional malaise. Just because someone is not able to speak does not mean that they do not have access to language or that they are not capable of self-directing their own medical care if given the option to do so in writing. (TIMER CHIME) Frustratingly, even when it is explicitly requested…

SERGEANT-AT-ARMS: Thank you. Your time expired.

CO-CHAIRPERSON LEE: Oh no, if you could just wrap up in a couple sentences. Okay. Yeah, go ahead.

MIRANDA STINSON DENOVO: Even when it's explicitly requested as an accommodation under the

ADA, many medical institutions and social services agencies refuse to communicate with patients via email or text message, incorrectly citing HIPAA. While appointing a loved one or caregiver as a healthcare proxy may be an option for some, this presents undue administrative burden and requires patients to give up a crucial piece of their autonomy, often at significant risk to their safety. In the worst case scenario, this opens the door for caregiver abuse. And I just want to reiterate, I'll send in the rest of the testimony, but there is no rule in HIPAA that says you can't communicate with patients in writing. It's just something that takes some setup to do. Long COVID might be a new phenomenon to some extent, but these are not new requests. A lot of them are things the deaf community and autistic community have been asking for for decades. And in the spirit of universal design, I want to remind you that if you make an accommodation that helps one community, you're going to improve the lives of another community as well. Thank you so much.

CO-CHAIRPERSON LEE: Thank you so much. And as you said, it's requests that are not new, but

this population is new so I just want to thank you for shedding light to that issue, and hopefully this is something that can create more coalition around advocacy so thank you.

Okay. Next up we have Melissa O'Brien followed by Christopher Leon Johnson.

SERGEANT-AT-ARMS: You may begin.

MELISSA O'BRIEN: Hi. Thank you. My name is Melissa O'Brien. I'm the Medical Director of Psychiatric Services at Project Renewal, a non-profit that's been serving New Yorkers experiencing homelessness, mental illness, and substance use for over 55 years.

Today, I want to talk about how people with mental illness and disabilities have been left behind by our healthcare system that simply isn't designed with them in mind. Many of our clients struggle to access care because of long wait times, crowded clinics, and confusing paperwork. For someone experiencing severe symptoms of mental illness or living with trauma, just sitting in a waiting room can be too much. For example, a patient diagnosed with schizophrenia may be experiencing paranoia, auditory hallucinations, or delusions. These symptoms

can create additional barriers to pursuing and receiving care for a cancer diagnosis. The patient may have difficulty navigating complex language, difficulty scheduling appointments, difficulty understanding next steps, difficulty in crowded waiting rooms, and difficulty sitting through tests and also following through with medication regimens. At Project Renewal, we've stepped in. Our staff help clients make appointments, explain medical instructions, escort them to providers, and ensure that they don't fall through the cracks. This includes our occupational therapy team, which plays a unique and essential role. Our OTs help clients build routines, manage appointments, and gain confidence to engage in care. It's a model that works, but it's not funded at a scale that is needed. We also face huge system barriers like pharmacy restrictions, Medicaid red tape, reimbursement for telehealth, and long wait times for specialists like neurology, which is critical for aging clients with head trauma or dementia. Our staff often spend hours resolving these issues. We've created solutions like in-house psychiatry, mobile medical clinics, but we can't do it all alone. We're asking the Council to invest in

community-based care teams, expand psychiatric and specialty care access, support transportation for people who can't use public transit, and fund the bridge services that keep people connected to care.

Access to healthcare should not depend on whether someone has a case manager who can spend hours navigating broken systems, but should be a right. Thank you for the opportunity to testify, and I'm happy to answer any questions.

CO-CHAIRPERSON LEE: Great. Thank you so much.

And next, we have Christopher Leon-Johnson.

SERGEANT-AT-ARMS: You may begin.

CHRISTOPHER LEON JOHNSON: Hello. My name is Christopher Leon Johnson. I'm at Home Depot right now. I'm doing some gardening.

So, I want to speak on behalf of this Committee, and I want to show my support for it. I want to show my support, and at the same time, I want to make sure that the people that have, like, lesser than serious mental illnesses are able to access the same mental health, same services. Because I see that they don't, the City and the State doesn't cater to

anybody who don't have, like, lesser than serious mental illnesses like bipolar disorder, and only people who have schizophrenia and psychosis. Until that happens, nothing's going to be accomplished in the city with this stuff. We have a big mental illness crisis in the city, and everybody knows what the symptoms are, but they don't treat it as disabilities. These people are able to get the help they should be getting. At the same time, I see that there was certain hearings about the masks, about face masks and stuff like that. I understand for people that are disabled, but that should only be the exemptions for people who are disabled and people who have mental health issues, not people that are going over the city and committing crimes for the guise of politics like Palestine or Israel. It shouldn't be like that. Let's keep that 100 percent the same. Going back to mental health, there needs to be a bigger outreach and overall definition to mental health and mental illness in the City of New York, other than just making it like you have to be a real psychosis or schizophrenia to be helped. What about people with bipolar disorder? Help people who have less mental illness. At the same time, we have to

make sure that these people are taken care of at the clubhouses, too. We had a hearing last month about those. So we need to take care, make sure that people are taken care of with clubhouses, also. Yeah. So, like I said, bipolar disorder and lesser mental illnesses need to be classified as serious mental illnesses, (INAUDIBLE) going to be going forward (TIMER CHIME) I've got to go. I've got to go.

SERGEANT-AT-ARMS: Thank you. Your time has expired.

CHRISTOPHER LEON JOHNSON: Enjoy your day.

CO-CHAIRPERSON LEE: Thank you and happy gardening.

Okay. So, I'm just going to call a bunch of names, and if you are here, please let us know you're here. If we missed you, we apologize. So I'm just going to go through a few names. Glen Bolofsky, Alex Stein, Joo Han, Sarah Fajardo, Carla Rabinowitz, Ryan Benscoter, Avonne Parra.

Okay. Avonne Parra, I believe you just signed on so, if you are here, let us know.

AVONNE PARRA: I'm here.

CO-CHAIRPERSON LEE: Oh, okay. Perfect. So, you have two minutes, so the Sergeant-at-Arms will start your time.

SERGEANT-AT-ARMS: You may begin.

AVONNE PARRA: Give me one second. Okay. So, thank you all for having me. There's a real inadequacy when it comes to the Gender Act in the hospitals and the care that patients receive because of their gender identity, and it's been a really, really bad situation for me as well as a tragic and devastating situation for one of the community advocates that passed away this past week from a hospital being negligent first with handling their care, and there needs to be some things that change about that. Staff needs to be trained in these hospitals on the Gender Act because it's the law, and they're violating people's legal rights now when they're going to these hospitals, calling them sirs or calling them out of their preferred name, and sometimes even giving them lackluster care because of their gender identity, and that's not right. That's all I have.

CO-CHAIRPERSON LEE: Great. Thank you so much for bringing attention to this important issue so thank you.

Okay. And really quickly, I'd like to acknowledge we've been joined by Council Member Selvena Brooks-Powers.

Do you have any questions?

Okay. Great.

Okay. So, thank you to everyone who has testified.

If there is anyone present in the room or on Zoom that has not had the opportunity to testify, please raise your hand.

Okay. Seeing no one else, I would like to note that written testimony, which will be reviewed in full by Committee Staff, may be submitted to the record up to 72 hours after the close of this hearing by emailing it to testimony@council.nyc.gov. And especially for folks online, if there's any follow-up, I want to thank all of you for sharing your testimony, especially Avonne. I know you just joined us, but appreciate all of you bringing these issues to light. They are all very important issues, and so thank you all.

And I believe with that, I just want to conclude our hearing and close out. Thank you, everyone. [GAVEL]

C E R T I F I C A T E

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

Date May 24, 2025