Testimony of Alicia Butler, RN

Oversight- - The Department of Correction and Correctional Health Services Management of COVID-19

Virtual ***September 21, 2019***

Good Afternoon. My name is Alicia Butler, I am an RN, working at NY Health & Hospitals Correctional Health Services-Rikers Island for 18 years. I am a member of New York State Nurses Association which represent 42,000 registered nurses. Thank you Chair Carlina Rivera and Chair Powers for holding this hearing on DOC and CHS Management of COVID 19.

I first want to speak on the distribution of PPE. Initially COVID patients didn't wear mask. They would be issued one mask from nursing but never receive another one from DOC. Even Nurses working in COVID areas only received N-95 mask after a long fight.
It still isn't clear if all officers have access to mask because many still enter and work in facilities where mask are not enforced. Nurses wear mask when treating COVID patients but if other staff do not follow protocol we are creating unsafe conditions. Although mask are mandated within DOC facilities there is little or no enforcement.

Screenings are another area where we need improvement. There is a delayed response for staff screenings. Officers are taking temperatures opposed to clinical personnel. Clinical training is needed for a proper screening, allowing us to see signs of other symptoms. We have had situations where people have had to be removed after entry due to symptoms. I would recommend that the body scanners are operated by CHS not DOC.

Currently we still do not have testing available at Rikers or in the surrounding area for CHS or DOC staff. Getting numbers on patients and staff was very difficult. Labor Relations should create a system for sharing this information.

Moving forward let's prepare to protect patients and staff in our correctional facilitates. DOC numbers are low enough to house inmates and enforce social distancing. We need to make an effort to be proactive prior to another wave of COVID.

Last I will mention that CDC initial regulations worked against us during COVID. Infectious Disease follows certain protocols to protect patients. PPE is designed to discard after each infected patient and these regulations forced us to work in an unsafe manner.

Let's begin a "No Mask No Entry" campaign and make sure it's enforced. We need regular labor-management meetings for reporting COVID numbers. Thank you for your time today.

TESTIMONY OF:

Kelsey De Avila – Project Director, Jail Services

BROOKLYN DEFENDER SERVICES

Presented Before
The New York City Council Committees on Criminal Justice & Committee on Hospitals

Oversight Hearing of The Department of Correction and Correctional Health Services Management of COVID-19 in Jails

September 21, 2020

Brooklyn Defender Services (BDS) provides comprehensive public defense services to nearly 30,000 people each year, thousands of whom are detained or incarcerated in the City jail system either while fighting their cases or upon conviction of a misdemeanor and a sentence of a year or less. We thank the Committees on Hospitals and Criminal Justice and Chair Rivera and Chair Powers for calling this necessary hearing.

Six months after COVID-19 was declared a pandemic by the World Health Organization,[1] the number of global deaths is approaching one million, with nearly 31 million individuals infected.[2] Prisons and jails around the country have been petri dishes for the virus, as it spreads through units and buildings, infecting incarcerated people and staff alike, while the known methods for containing the spread of the virus—such as mask-wearing, social distancing, and systematic cleaning—are difficult if not impossible to implement in these settings.

In May of this year, the City Council Committee on Criminal Justice and Committee on Justice System held a joint hearing on the COVID-19 response in our City jails. Directly impacted people, advocates and defender offices in NYC said the same thing: Department of Correction (DOC) and Correctional Health Services (CHS) had failed to be transparent. That opaqueness

[1] World Health Org., *WHO Director-General's opening remarks at the media briefing on COVID-19* (Mar. 11, 2020), https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020.
[2] Center for Systems Science and Engineering, Johns Hopkins University, COVID-18 Dashboard, https://coronavirus.jhu.edu/map.html (last updated September 24, 2020 at 10:23 am).

Lisa Schreibersdorf
Executive Director
@BklynDefender

177 Livingston Street, 7th Floor
Brooklyn New York 11201

T (718) 254-0700
www.bds.org
F (718) 254-0897

created mistrust, lack of accountability, and failed to adequately address the public health crisis at hand. DOC and CHS had not provided, and still have not provided, a comprehensive response plan, and they failed to share vital information with people in custody and the community. Four months later we find ourselves in a nearly identical position, with little progress. Our office and the offices of other defender legal providers have made countless attempts requesting information with little or no response. As just one example, on Friday, September 11, the NYC defender offices wrote to the DOC, CHS and the BOC requesting information on COVID-19 protocols. As of today, the NYC defender offices have not received a response.

City agencies are asking the press, the oversight agencies, and the public to believe one narrative, but that narrative is far divorced from the experiences of those directly impacted. These agencies' narratives largely describe how things *should* be, not how they actually are. They reflect policies and official guidance—despite those policies not being shared. The other narrative, the one we hear each day that is lived by directly impacted people, is the experience of people who see firsthand how those spoken policies are failing. For six months we have seen a City reluctant to enforce the version of the narrative shared by the City agencies – one that is, at best, aspirational – there's no transparency around basic safety protocols, compliance measures, accountability structure for staff who don't comply.

With the looming threat of a second wave, no written policies on COVID-19 safety measures from DOC and CHS, numerous reports of staff non-compliance with PPE, the public is left with no assurances Department of Correction and Correctional Health Services are equipped to handle this ongoing crisis.

COVID-19 is Still a Threat

There is no question that NYC has made tremendous progress maintaining control of the virus. Nonetheless, cases are cyclical, and we know the virus is still spreading in New York[3] and around the country. As that happens, increased infections in NYC jails are nearly inevitable as experts assure us a second wave is ahead.[4] We know COVID-19 will enter NYC jails one of two ways: staff and jail admissions. As we prepare for a potential second wave, we can almost guarantee that when and if it does hit NYC, the jails will become the epicenter once again.

Over the course of six months, people in custody have been sharing their direct experience with continued confusion about testing practices, housing determinations and access to services and family. The experience of one person represented by BDS from the time of their arrest through numerous transfers instead DOC housing units demonstrates the high risk of exposure and how the virus does and will continue to spread, without specific policies and practices designed to counteract the danger:

[3] https://rt.live/ (showing an infection rate above 1.0 for New York, demonstrating that each infected person is infecting more than one additional person)
[4] https://www.nbcnewyork.com/news/coronavirus/six-nyc-neighborhoods-see-spike-in-covid-19-cases-as-fears-of-second-wave-mount/2631102/.

Mr. B is arrested on 8/1/2020 by two police officers who were not wearing PPE. [5] [6] [7] *Mr. B is taken to Brooklyn Criminal Court ("Central Booking") where he is held in a large cage with 10-15 other men and where it is impossible to socially distance from one another. Mr. B is held in Central Booking for several hours until he is called in front of a judge and bail is set. A while later, Mr. B is led to a DOC bus with 10 other men and forced to sit directly next to another person where the two are handcuffed together. Mr. B has not been tested recently and does not know if he is positive for COVID-19 or if the man he's now handcuffed to might be. Mr. B is already overwhelmed with the stresses that follows anyone entering a jail, but that stress is now exacerbated by the lingering threat of COVID and knowing he has been in close proximity to many others.*

Upon arriving at the Manhattan Detention Complex, Mr. B exits the bus and is left in an intake holding cell, again with 10-15 other men. These are not the same men he was with in Central Booking and not all are from the same bus he came in on. His potential exposure to COVID-19 has now increased. One day after arrest, 8/2/2020, Mr. B is moved from the intake holding area to the New Admission Housing unit. In this unit are men who did not enter the jail on the same day as Mr. B, but days before. Within 4 days on 8/6/2020, Mr. B is tested for COVID-19 in his unit, and verbally informed by CHS staff that he will receive his results in 10 days and he will not be moved until his results are confirmed.

Mr. A is also incarcerated and entered the same new admission housing unit a few days prior to Mr. B. Mr. A was tested on 8/1/2020, the day before Mr. B arrived in the new admission housing unit and was verbally told he will not be moved until his results are confirmed. Mr. A did not receive verbal or written documentation of his COVID-19 test results but was moved to a new housing unit in a new facility 10 days after getting tested for COVID-19. (his attorney received his test results before Mr. A, and Mr. A later learned those test results were negative).

Mr. A is anxious because he does not know the answers to his test results, and now men in his new housing unit are asking him questions if he's positive or if he has proof of his test results. He doesn't, and now the tensions in the unit have risen. Mr. A has signed up for sick call and requested his test results only to be told by CHS, "we'll look into it." He can only assume he's not positive because he's not witnessing anyone in the unit sick, but he does not know for sure.

Meanwhile, Mr. B is still in the new admission housing unit waiting for his results. They come back on the tenth day, and Mr. B is positive for COVID-19. He is moved to the contagious disease unit at West Facility.

Mr. A and Mr. B spent a total of 9 days together in the New Admission Housing unit. Both were allowed out of their cells during the day, used the telephones, used the same showers

[5] https://www.nytimes.com/2020/06/11/nyregion/nypd-face-masks-nyc-protests.html
[6] https://www.rollingstone.com/culture/culture-news/nypd-masks-bella-hadid-1041003/
[7] https://gothamist.com/news/called-out-not-wearing-mask-nypd-officer-calls-teen-male-version-karen

and even interacted. The unit had a bucket of dirty water next to the telephones, and understandably so, no one was using it to clean the shared telephones. The showers were being cleaned every other day, but not after every use.

The above is one account, but it represents many stories our office has heard and continues to hear. Infected people—many who may not know they are infected, and may even have tested negative—can spread the disease not only by direct contact (such as congregating with fellow incarcerated people in a jail or having direct contact between an incarcerated person and a corrections officer) but also through indirect contact (such as touching a surface in a communal bathroom or eating space, or sharing breathing space in an enclosed dormitory lacking access to outside air circulation.[8]
After Mr. B was found to have tested positive, what remains unclear is how Mr. A is notified and if and when the people in Mr. A's new housing unit are also notified and retested.

We do not know how and if Mr. A was informed of his exposure to a positive case while in New Admission Housing. We do not know if Mr. A is allowed to retest following his known exposure—we hear conflicting reports from people in the jails and based on what CHS and DOC represent—and we do not know if the people in his new unit are also informed and or allowed to retest. What action steps are being taken to make sure people, including those detained and staff, are made aware of potential exposure and have the right to retest for COVID-19?
Mr. A may also have exposed others like Mr. C who was handcuffed to Mr. A on the bus as he was transferred from New Admission Housing, Mr. D who was intaked with Mr. A and was moved to different facility, and all the other individuals who those people have encountered. Similarly, Mr. B was in close proximity with others at the start of his contact with the criminal legal system – his arrest by two NYPD officers, who were not wearing masks; the Brooklyn criminal court holding areas; handcuffed to another person on the DOC bus and then again in a holding area in the DOC facility intake. How far back will authorities go to notify those Mr. B was in close proximity? These are all questions that neither DOC nor CHS have answered, but necessary information to assess the safety of our jails.

Contact Tracing

BDS acknowledges that contact tracing is key to slowing and preventing the spread of COVID-19 to our friends, loved ones and community. Our community includes, and has always included, the City jails, yet jails and the people NY chooses to incarcerate are often left out of the discussion. We are failing to recognize the significance jails have on a community during a pandemic. Due to the transient and consistent movement that a jail represents, people will be exposed to a virus, and the potential for spread to and from the community is astronomical. We have witnessed this throughout the pandemic – rather than before and now amid a pending second wave. City and state officials are failing to prioritize the safety guidelines for all NYC jails and prisons, and this is having a direct impact in how data is being collected, testing is practiced and how information is shared across all NYC and NY state.

[8] Centers for Disease Control and Prevention, How COVID-19 Spreads, https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/how-covid-spreads.html.

Nonetheless, the City's decisions thus far with regards to Test & Trace risk exposing New Yorkers' most intimate details—their daily whereabouts, friends and family, private health information—to criminal, family, and immigration enforcement authorities, as well as other private actors.

Further, beyond just the privacy implications, other crucial details of the effort to deploy contact tracing in the City's jails remain unknown and problematic. CHS claims they are in partnership with DOC in contact tracing efforts, but what those specific efforts mean in practice has yet to be explained or shared. When our office asked CHS for clarification about contact tracing efforts, we are simply told "it's complicated." There is no question that the systems before us are "complicated," but using that as an excuse to refuse to share those specifics with the public during a pandemic is absurd at best and dangerous at worse.

To CHS' credit, they have provided written responses to some questions, but those responses lacked any specificity and failed to answer the question posed. Instead, responses are in general, overarching themes that give little assurance and faith the agency has the capacity to fulfil their responsibilities. And most importantly, we are still left with many unknowns, including how information is stored or used and what privacy protections are in place.
Our office will be testifying and submitting testimony for the joint Committee on Health and Committee on Hospitals oversight hearing on NYC's COVID-19 Testing and Contact Tracing Program, Part II scheduled for Wednesday, September 30, 2020. We will provide substantive information outlining our concerns and I encourage both Committee on Hospitals and Committee on Criminal Justice to review.

Access to Tests

Since early in the pandemic, the jails have touted broad testing efforts: namely, CHS claims to provide COVID-19 screenings at "every contact point of the criminal justice process." This purported blanket access is simply contrary to what people in the jails experience in practice. Specifically, CHS claims to test "pre-arraignment, admission, clinical encounters, and discharge." It is unclear from CHS's own statements if testing is supposedly available to all, or only if the person is symptomatic and/or if aware of exposure to a positive case. The majority of people in custody that we speak to were only tested at time of admission, and requests for a second test to confirm results or the ability to retest later in their incarceration is ignored or denied without reason.

This inadequate practice exacerbates other risks when people are frequently moved from one unit to another, or from one facility to another by the Department. When our office asked CHS for clarification about testing upon transfer to a new facility, the response was "it isn't practical" because transfers happen often and are not health driven. If we assume a person in custody is negative because they tested negative weeks ago, what is to prevent them from contracting the virus by staff who come and go daily? What prevents that now-positive person from spreading the virus to countless others, who were similarly tested weeks ago?

CHS has stated they have learned a lot in how they respond over the course of this pandemic. We urge the Council to require they share those findings, including what is working and what

knowledge has been gained. We are all experiencing this pandemic together, we are all learning and we are all adjusting our practices in how we move in our roles, and withholding information that is vital to public health puts us all at risk.

Deaths due to COVID-19 Complications Post-Release

Throughout the pandemic, media outlets have detailed the stories of people who contracted the disease and subsequently died. Noticeably absent from this group is the lives of people who contracted the disease while in custody and died after being released. COVID-19 has rampaged New York City's jails. Over 2,000 incarcerated people and jail staff were infected, and at least three incarcerated people and at least thirteen staff members have died. These statistics do not include individuals who may have succumbed to the virus after being released or whose death may not have originally been attributed to COVID.[9]

The public has demanded this information time and again, and yet the Department and CHS have made little to no effort to gather or share this information. The City Council has an opportunity to understand, and accurately portray the true impact COVID-19 had and continues to have on City jails.

Decarceration is Paramount Yet Incarceration Rates Are Increasing

As both public defenders and jail-based health care experts made clear in the early stages of the COVID-19 pandemic, releasing people from jail is paramount to protecting their health and the health of the broader public, and remains so. Social distancing and proper hygiene are uniquely challenging if not impossible in jails, as well as in prisons, immigration detention facilities, and other secure facilities. Indeed, jail and prison administrators across the country who conducted widespread testing, including here in New York City, found extremely widespread COVID-19 infection rates among incarcerated people. Conversely, New York State DOCCS has not conducted sufficient testing. This is alarming. Incarcerated people's lives matter, and because outbreaks behind bars threaten all of us, as many people, particularly staff, regularly enter and exit the facilities. An outbreak in a jail or prison will not be contained by prison and jail walls.

In response to the public health mandate, New York City initially moved toward decarceration, likely saving lives. Unfortunately, too many were left behind. Months later, this trend is now reversing. Defenders were able to get many of the people we serve released through writs of habeas corpus, Mayor de Blasio's administration assisted with the release of many New Yorkers in jail on "city sentences" for misdemeanor convictions, and the state agreed to the release of many people detained for alleged technical parole violations. At the same time, people continue to be detained on such alleged violations. Moreover, since rollbacks to the State's new bail

[9] [1] Brad Maurer, et al., *There must be mass releases from NYC's jails immediately—it's the only way to protect public health*, The Appeal (July 9, 2020), https://theappeal.org/there-must-be-mass-releases-from-nyc-jails-immediately-its-the-only-way-to-protect-public-health/; NYC Board of Correction, Weekly COVID-19 Update Week of August 22-August 28, 2020, https://www1.nyc.gov/assets/boc/downloads/pdf/covid-19/boc_weekly_report_8_22_8_28_2020_updated_final.pdf.

reform laws took effect in the beginning of July, which expanded judges' ability to set money bail in cases involving only allegations of nonviolent offenses, the daily jail population has increased by hundreds of people. This increase likely corresponds to a significantly larger number of New Yorkers admitted to local jails and exposed to these unsafe conditions before being released into some of the communities hardest hit by COVID and the scourge of racism.

Importantly, nothing in the current bail statute should result in any increase in pre-trial detention, as money bail, if and when it is imposed, is intended to serve as a gateway–not a barrier—to liberty. Excessive bail is unconstitutional and now there is an explicit requirement in the law that judges concern a person's ability to pay, as well as other crucial protections. Yet prosecutors continue to seek and judges continue to set unaffordable bail, including in cases that should not be eligible for money under the law. In particular, defenders are challenging the abuse of CPL 510.10 (4)(t), which permits bail to be set in cases where a person is released pending trial on any A misdemeanor or felony charge involving alleged harm to an identifiable person or property and is arrested on a subsequent charge meeting the same criteria if the prosecutor can show reasonable cause. For example, people are being jailed pre-trial on cases involving only minor theft allegations, even after the property in question is recovered undamaged.

All stakeholders should be working together to quickly resume decarceration in New York City before further spread of the virus or the predicted second wave of COVID-19 hits.

Conclusion:

We acknowledge the challenging, yet critical, responsibility the Department and CHS are tasked with, especially considering it is impossible to sanitize and socially distance in a jail that has both a transient and increasing population. However, the barriers jail imposes should not excuse City agencies charged with the care and custody of people from communicating those responsibilities and how they plan to enforce their policies. Jail is inherently violent, and the walls surrounding keep people—and the virus—in, just as much as they keep people out. People in custody have families and loved ones that receive bits of information that are pieced together to try and build an understanding, but what is still unknown creates fear and anxiety for the safety of their loved ones. This City has an obligation to report accurate information about how its' agencies are operating and their plans to ensure people in DOC custody are healthy and safe.

The testimony I've shared today is based on the experiences of people incarcerated in NYC jails, however it is also vital the Council hears directly from people inside who wish to share their own lived experience. We urge City Council to promote opportunities for people in custody to share what they are witnessing at these hearings, at Board of Correction hearings, and at other public forums through video testimony and comment. Transparency is essential, and we can begin to hold those accountable when we start listening to those directly impacted. We are living in a virtual world where we have both the means and capabilities to make that happen now more than ever.

If you have any questions, please don't hesitate to contact me at kdeavila@bds.org. Thank you.

Community Health Care Association of New York State Written Testimony
NYC Committees on Health and Hospitals:
NYC's COVID-19 Testing and Contact Tracing Program, Part II
September 29, 2020

The Community Health Care Association of New York State (CHCANYS) thanks the NYC Council for their attention to critical issues surrounding the response to the novel coronavirus (COVID-19) pandemic. On behalf of the 1.3 million patients that our members serve at 459 sites throughout New York City, we submit this written testimony to the joint Committees on Health and Hospitals.

Located in low-income communities serving mostly people of color, community health centers (CHCs) have a documented history of providing high quality and effective primary care to anyone who requires services, regardless of insurance status, immigration status, or ability to pay. In NYC, 14% of CHC patients are uninsured, 62% are enrolled in Medicaid or CHIP, 75% identify as Black, Hispanic, or Latinx, and 30% are best served in a language other than English. COVID-19 has disproportionately impacted the very communities we serve: low-income communities, communities of color, and people with comorbidities. Therefore, CHCs remain the ideal partner to collaborate with the City in its effort to test and treat New Yorkers across the City as the City experiences rising infection rates, with a positive testing rate now exceeding 3 percent.

During the first NYC Council hearing on New York City's plan to test and trace for COVID-19, we testified that CHCs stood ready and committed to partner with the Department of Health and Mental Hygiene (DOHMH) and the rest of the NYC government to ensure the ongoing safety and health of all New Yorkers. However, we reported that DOHMH guidance[1] and limited access to personal protective equipment (PPE) drastically inhibited CHCs' ability to meaningfully participate in the City testing and tracing initiatives. Today, we are happy to share that DOHMH has since reversed the guidance and committed to ensuring that CHCs are equipped with PPE to promote the safety of our patients and staff in the battle against the spread of COVID-19. We are grateful to the NYC government and DOHMH for taking these critical steps to ensure meaningful participation by CHCs in the COVID-19 testing and tracing initiatives.

NYC based CHCs have implemented COVID-19 testing programs. Some have implemented these programs within the four walls of their health centers, others have set up mobile testing areas or parking lot tents, and still more are developing additional plans to adjust COVID-19 testing workflows in the winter months. To date, our members have conducted thousands of COVID-19 tests and have capacity to continue to serve patients throughout the City, including in the neighborhoods that have been identified as new potential hotspots in recent days. Yet, challenges around testing remain.

Many health centers have expressed concerns around the availability of rapid testing equipment – something that is widely available among private health care providers in New York City. The need for rapid testing equipment is especially heightened because health centers, like other community

[1] https://www1.nyc.gov/assets/doh/downloads/pdf/han/advisory/2020/covid-19-03202020.pdf

New York City Office 111 Broadway, Suite 1402, New York, New York 10006 T 212-279-9686 F 212-279-3851
Albany Office 90 State Street, Suite 600, Albany, New York 12207 T 518-434-0767 F 518-434-1114

providers, are experiencing long delays in receiving COVID-19 testing results. Wait times for test results of up to 10 business days are reported in New York City. As students head back to school and more persons under investigation for COVID-19 are tested, existing challenges around delayed test results will only become exacerbated. It is crucial for the City to take measures to reduce wait times associated with COVID-19 test results. One way to do this is to work with CHCs to ensure adequate access to rapid testing devices and providing clarity as to how CHCs will be reimbursed for tests that the City has assured will not be a cost to relevant cohorts (e.g.: students and teachers).

To compound problems around long delays in receiving test results, there is conflicting guidance around when a person under investigation for COVID-19 should return to work or school. For example, some schools state that only after a negative test result may a student or staff return to school. Other guidance states that when testing is unavailable, individuals who are no longer feverish may return to school. To ensure the safety of students and staff, we seek consistent, Citywide guidance and requirements for testing of persons suspected of having COVID-19 and clarity on circumstances under which a staff member or child may return to school premises. We recommend that provider input be a heavily weighted factor when determining whether or not a student or staff member may return to school.

CHCANYS is proud that its members operate school-based health centers ("SBHCs") throughout all five boroughs. As schools reopen, SBHCs are the logical health care provider of choice for students. However, SBHC licensure restricts them from providing care beyond the student population to parents and/or staff. CHCANYS has asked the State to adjust SBHC licensure on a temporary basis to allow SBHCs to provide COVID-19 testing beyond the enrolled student population.

Provided that the City is able to assist in ensuring CHC access to rapid testing equipment and the guidance provided by the City improves, our CHCs stand ready to provide testing and support for individuals with confirmed or suspected COVID-19, including in those geographic areas where the City may be experiencing spikes. As always, CHCs remain proud to partner with NYC to ensure the health and well being of all New Yorkers.

If you have questions or follow up, please reach out to Marie Mongeon, Director of Policy with CHCANYS: mmongeon@chcanys.org.

New York City Office 111 Broadway, Suite 1402, New York, New York 10006 T 212-279-9686 F 212-279-3851
Albany Office 90 State Street, Suite 600, Albany, New York 12207 T 518-434-0767 F 518-434-1114

Manhattan
841 Broadway
Suite 301
New York, NY 10003
212/674-2300 Tel
212/254-5953 Fax
646/350-2681 VP

Queens
80-02 Kew Gardens Rd
Suite 400
Kew Gardens, NY 11415
646/442-1520 Tel
347/561-4883 Fax
347/905-5088 VP

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Testimony to New York City Council Hearing:

NYC's COVID-19 Testing and Contact Tracing Program, Part II

Submitted by
Margi Trapani
Director of Education

Testimony to New York City Council Hearing:
NYC's COVID-19 Testing and Contact Tracing Program, Part II

Thank you for holding this hearing regarding New York City's Testing & Contact Tracing program. We are grateful to the oversight committee for its vigilance in monitoring the program. We appreciate the opportunity to elevate some of our concerns.

The over 900,000 people with disabilities in New York City face gross health disparities. Nearly three out of four New Yorkers with disabilities report a chronic health condition compared to 32 percent of their non-disabled peers. There is a gap of six to 10 percent between people with disabilities and their non-disabled peers who report getting regular basic health tests including mammograms, pap tests and dental exams.

According to U.S. Census figures, we live in long term poverty: slightly over 35 percent of us live at or below 100 percent of the poverty rate – a 15 percent gap from our non-disabled peers. Fifty-eight percent of us live at or below 200 percent of the poverty rate – a 19.5 percent gap from our non-disabled peers. We represent 12 percent of the Black/African American population; 11.6 percent of the Hispanic population; 11.3 percent of the White population; 7.2 percent of the Asian population and 10 percent of us identify as "other."

These rates reveal the intersections of population groups that are overrepresented in COVID-19 positive rates and people with disabilities. We are also aware that historically, people with disabilities face lack of Americans with Disability Act (ADA) compliance at doctors' offices, clinics and hospitals. As an organization that advocates for and represents people with disabilities we have several issues of concern for our population as the Testing and Tracing Program continues.

As people are tested and/or are subjects of contact tracing, we are gratified that testers and tracers now ask the American Community Survey questions regarding disability so that rates among our population can be tracked. This information should be made public along with other demographic data so that organizations serving people with disabilities can use it to inform their service provision and their education work. It puts health professionals on notice that individuals may require reasonable accommodations during treatment because of barriers that people with physical, hearing, speech, vision, cognitive and mental health disabilities face in seeking care.

We have heard from people with disabilities that many are distrustful of medical personnel's understanding and accommodating their disabilities based on historical discrimination and recent experiences. Some also report that they are reluctant to go to new sites for any medical/health care needs since they don't know how or if they will be accommodated. In one case a representative of an organization that works with people who are blind or low vision told us that their membership is avoiding going to health clinics or hospitals they have not been to before out of concern regarding how they will be treated.

We are concerned that testing sites may not be fully accessible according to ADA standards of compliance. We have been told that all testing sites are accessible, but since there is no definition of accessibility offered, it is unclear what this means. Did sites merely attest to "accessibility?" Was there actual examination of facilities and their policies and procedures? Accessibility for people with ambulatory disabilities, while critical, only accounts for a little over 7 percent of New Yorkers with disabilities. What

accommodations are available for those who are Deaf or Blind? What are the accommodations available to those who have cognitive or intellectual disabilities and need more explanation or help understanding testing and then if positive what support they can get. We had comments from people with Cerebral Palsy and other neurological conditions whose body movements, including spasticity, can inhibit their ability to take the test unless a knowledgeable health care professional can work with them to accommodate their needs. Individuals with speech disabilities express concern that they will not be listened to if their speech takes longer or is not easily understood. Are testers trained to work with people with disabilities who face barriers in the health environment that need to be removed so that they can get care?

When we are told that sites are accessible, how is that determined? We know that self-attestation often misses key accommodation and accessibility needs. We know that what a site may consider access is often less than required by the ADA.

It is unclear to us how testing for the numbers of homebound seniors and people with disabilities is or will be accomplished. This population should be included in testing and tracing but we have no assurance that they will be. NYC HRA has lists of low-income people with disabilities who are homebound. When we ask, we are told that "home testing protocols are pending." This has been true since the beginning of the testing program. Many seniors and people with disabilities live alone but have support people coming to their homes, whether they are paid aides or family members. There is no way to know whether they are being exposed to the virus without testing, yet our questions about home testing have not been answered. This most vulnerable population has no way to go outside the home for testing. Many can handle their self-care needs, but would not be able to administer the test without help, even supposing that they can receive a home testing kit. What provisions are being considered or made for this population?

We look forward to continuing to work with you to ensure that all New Yorkers have access to testing for COVID-19 and that there is appropriate support for those who test positive for the virus.

-END-

Legislative Affairs
One Whitehall Street
New York, NY 10004
212-607-3300
www.nyclu.org

Testimony of Allie Bohm
On Behalf of the New York Civil Liberties Union
Before the New York City Council Committees on Health and Hospitals
Regarding *Oversight of* NYC's COVID-19 Testing and Contact Tracing Program, Part II

September 30, 2020

The New York Civil Liberties Union (NYCLU) is grateful for the opportunity to submit the following testimony regarding New York City's COVID-19 testing and contact tracing program. The NYCLU, the New York State affiliate of the American Civil Liberties Union, is a not-for-profit, nonpartisan organization with eight offices across the state and over 180,000 members and supporters. The NYCLU defends and promotes the fundamental principles and values embodied in the Bill of Rights, the U.S. Constitution, and the New York Constitution through an integrated program of litigation, legislative advocacy, public education, and community organizing.

Virtually all New Yorkers share the fervent desire to safely re-open the City, and there is broad consensus that contact tracing is an essential component to doing so.[1] Unfortunately, a necessary ingredient for effective contact tracing – community trust – is still missing.

In March, New York had the unenviable task of pivoting on a dime to try to save lives and stem the spread of the worst pandemic this country has experienced in a century. Unfortunately, in that process, too little attention was paid to cultivating community trust. And, this trust deficit has not been remedied since. Indeed, New York City, like New York state, has doubled down on the very tactics that undermine trust and community participation in the COVID-19 response.

From the outset of the pandemic, Governor Cuomo has called on police to enforce coronavirus-induced social distancing restrictions.[2] Mayor de Blasio has repeatedly echoed

[1] *See Regional Monitoring Dashboard*, NEW YORK FORWARD, https://forward.ny.gov/regional-monitoring-dashboard (last visited May 26, 2020).
[2] Nathaniel Weixel, *Cuomo Says NYPD Needs to Enforce Social Distancing Rules*, THE HILL, Apr. 1, 2020, https://thehill.com/homenews/state-watch/490623-cuomo-says-nypd-needs-toenforce-social-distancing-rules.

this call, and his administration has insisted that the appropriate response to issues ranging from overcrowding in grocery stores[3] to the opening of city streets for pedestrian and bicycle traffic is heavy police presence and enforcement.[4] More recently, Mayor de Blasio has deployed law enforcement to implement quarantine checkpoints at the City's major bridges and tunnels,[5] and Governor Cuomo announced that restaurants in New York City would be permitted to open for indoor dining "if NYPD can enforce compliance."[6] Just last week, in response to "the Ocean Parkway [coronavirus] Cluster," police told the Daily News that the NYPD will monitor and break up large gatherings in Hasidic communities in Brooklyn in the midst of the Jewish High Holidays.[7]

Unfortunately, if unsurprisingly, law enforcement's role at the forefront of social distancing enforcement has resulted in racially disparate patterns of enforcement and criminalization of communities that have long been subject to aggressive over-policing.[8] According to data released by the NYPD, more than 80 percent of those ticketed for social distancing-related enforcement are Black and Latinx.[9]

Police are not the public officials best suited to respond to COVID-19 related restrictions for two reasons. First, the NYPD is not – nor should it endeavor to be – a public health agency. Second, the communities most impacted by the virus do not have sufficient trust in the NYPD – or in law enforcement in general – for its officers to function as effective public health messengers. This is true for Black, brown, and immigrant communities, who, thanks to a toxic cocktail of socioeconomic factors, physical environment, and inferior access to

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[3] Dave Goldiner, *De Blasio Asks NYC to Rat Out Coronavirus Crowders*, N.Y. DAILY NEWS, Apr. 18, 2020, https://www.nydailynews.com/coronavirus/ny-coronavirus-de-blasio-nyc-social-distancing-police-20200418-kidh4tqokzavbojoknoej2mv5y-story.html.

[4] Julia Marsh & David Meyer, *De Blasio Calls Off Coronavirus Street Closures, Citing Lack of NYPD Resources*, N.Y. POST, Apr. 6, 2020, https://nypost.com/2020/04/06/coronavirus-in-ny-de-blasio-calls-off-street-closures/.

[5] Eyewitness News, *Reopen NYC: Travelers face COVID-19 quarantine checkpoints at major entry points*, ABC7, Aug. 6, 2020, https://abc7ny.com/health/nyc-establishing-coronavirus-quarantine-checkpoints/6355344/?fbclid=IwAR1t3M_XcKETfw8TX8dilLNgBHNkWqh1HbiZT5nMDEok6-1pEgw7Rik8qqI.

[6] Governor Andrew Cuomo, Press Conference Call (Sept. 3, 2020). In response to questioning at a later press conference, Governor Cuomo did concede that "inspectors do not have to be police." Governor Andrew Cuomo, Press Conference Call (Sept. 9, 2020).

[7] Thomas Tracy & Shant Sahrigian, *COVID spike in south Brooklyn prompts warning of 'lockdown-type situation': de Blasio official*, N.Y. DAILY NEWS, Sept. 23, 2020, https://www.nydailynews.com/coronavirus/ny-coronavirus-ocean-parkway-cluster-bill-de-blasio-20200923-76jpcggrnrgejh6pliqudp2uni-story.html.

[8] *E.g. Stop-And-Frisk in the De Blasio Era (2019)*, NYCLU, Mar. 14, 2019, https://www.nyclu.org/en/publications/stop-and-frisk-de-blasio-era-2019; *New York Should Legalize Marijuana the Right Way*, NYCLU, Apr. 25, 2019, https://www.nyclu.org/sites/default/files/field_documents/20190425_marijuana_onepager_final.pdf.

[9] Erin Durkin, *Black and Latino New Yorkers Get Vast Majority of Social Distancing Summonses*, POLITICO, May 8, 2020, https://www.politico.com/states/new-york/albany/story/2020/05/08/black-and-latino-new-yorkers-get-vast-majority-of-social-distancing-summonses-1283223.

health care,[10] are disproportionately likely to suffer from COVID-19.[11] They are also disproportionately likely to be alienated from and distrustful of our health care system as a result of the racial biases that pervade that system.[12] This is also true of religious enclaves, such as New York City's Hasidic community, which has also been ravished by COVID-19,[13] still harbors deep distrust of the public health system and government after last year's bruising battle over the repeal of religious exemptions for vaccines,[14] and feels singled out by Mayor de Blasio for pandemic-related enforcement.[15]

As our nation stands in the midst of a long-overdue reckoning on racism, police brutality, and white supremacy, any distrust New Yorkers, particularly Black and brown New Yorkers, might have of contact tracers, who may, like law enforcement and many in the health care system, carpetbag in from outside of the community, feels understandable.

Both anecdotal evidence and New York City's own contact tracing data illustrate this distrust. In the wake of George Floyd's murder in Minnesota, law enforcement there began using contact tracing techniques to track individuals protesting white supremacy and police brutality, and public health officials immediately lamented that the involvement of police hampered their efforts to build trust and participation in COVID-19 contact tracing.[16]

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[10] *NCHHSTP Social Determinants of Health*, CENTERS FOR DISEASE CONTROL, https://www.cdc.gov/nchhstp/socialdeterminants/index.html (last visited May 14, 2020); *see also* Ibram X. Kendri, *Stop Blaming Black People for Dying of the CoronaVirus*, ATLANTIC, Apr. 14, 2020, https://www.theatlantic.com/ideas/archive/2020/04/race-and-blame/609946/.

[11] *Fatalities*, NYS DEP'T OF HEALTH, https://covid19tracker.health.ny.gov/views/NYS-COVID19-Tracker/NYSDOHCOVID-19Tracker-Fatalities?%3Aembed=yes&%3Atoolbar=no&%3Atabs=n (last visited May 26, 2020); *see also The Color of Coronavirus: COVID-19 Deaths By Race And Ethnicity in the U.S.*, AMP RESEARCH LAB, May 20, 2020, https://www.apmresearchlab.org/covid/deaths-by-race; John Eligon, Audra D.S. Burch, Dionne Searcey, & Richard A. Oppel Jr., *Black Americans Face Alarming Rates of Coronavirus Infection in Some States*, N.Y. TIMES, Apr. 14, 2020, https://www.nytimes.com/2020/04/07/us/coronavirus-race.html.

[12] Khiara M. Bridges, *Implicit Bias and Racial Disparities in Health Care*, 43 ABA HUMAN RIGHTS MAGAZINE (2018).

[13] Joseph Goldstein, *N.Y.C. Warns About Rising Virus Cases in Hasidic Neighborhoods*, N.Y. TIMES, Sept. 22, 2020, https://www.nytimes.com/2020/09/22/nyregion/coronavirus-Orthodox-Jewish-neighborhoods.html ("In late April, roughly 700 members of New York City's Hasidic community were believed to have been killed by the disease, and few families have been spared . . . In some areas with significant Hasidic populations, more than 40 percent of people being tested were found to have antibodies.").

[14] *See* Bobby Allyn, *New York Ends Religious Exemptions For Required Vaccines*, NPR, June 13, 2019, https://www.npr.org/2019/06/13/732501865/new-york-advances-bill-ending-religious-exemptions-for-vaccines-amid-health-cris.

[15] Liam Stack & Joseph Goldstein, *New York Threatens Orthodox Jewish Areas With Lockdown Over Virus*, N.Y. TIMES, Sept. 25, 2020, https://www.nytimes.com/2020/09/25/nyregion/coronavirus-orthodox-jewish-communities.html.

[16] Alfred Ng, *Contact tracers concerned police tracking protesters will hurt COVID-19 aid*, CNET, June 1, 2020, https://www.cnet.com/news/contact-tracers-concerned-police-tracking-protesters-will-hurt-covid-19-aid/.

Moreover, according to the data New York City Health + Hospitals (H+H) released on September 14th, contact tracers were able to reach 91 percent of cases for a live conversation, and 70 percent of cases completed the intake interview, but only 70 percent of those who completed the interview – note the change in denominator – actually shared their contacts with H+H.[17] This means that a mere 49 percent of COVID-19 cases shared contacts with contact tracers. And this 49 percent presumably includes individuals who only provided contact tracers with partial contacts.[18]

Although 49 percent is a slight improvement from the summer,[19] it is still woefully inadequate, particularly given that contact tracers are not only contacting New Yorkers who test positive for COVID, but also contacting individuals who come into the City from out of state and are subject to the Governor's travel advisory.[20] It is unclear whether the increased response rate is a reflection of New Yorkers' growing participation or simply cooperation from travelers subject to the travel advisory. Similarly, H+H has not released information about contact tracing participation disaggregated by neighborhood, zip code, race, ethnicity, or any other demographic measure that might help New Yorkers to ascertain whether – and why – certain communities are left out. The City Council should use its oversight authority to learn more about who the City's contact tracing program is reaching and who is still being left behind.

In the meantime, New York City already has the tools at its disposal to build the necessary trust in its contact tracing program – and the public health response more generally – if only it would use them.

In early July, H+H put out a request for proposals for test and trace (T2) community-based organization engagement opportunities. Although the request paid lip service to the importance of cultural and linguistic competency and authentic community engagement, it made clear that it was looking for community-based organizations to deliver the City's messaging both within their communities and outside of their communities without providing a mechanism for the community-based organizations to offer feedback on the

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[17] *Contact Tracing Program Performance Over Time*, NYC HEALTH + HOSPITALS, Sept. 14, 2020, https://hhinternet.blob.core.windows.net/uploads/2020/09/test-and-trace-data-metrics-20200914.pdf.
[18] *Cf.* Suzane Sataline, *Life as a Covid-19 contact tracer: sleuthing, stress, and veering off-script*, STAT, May 18, 2020, https://www.statnews.com/2020/05/18/coronavirus-contact-tracer-sleuthing-stress-veering-off-script/.
[19] *See* Erin Durkin, *Most New Yorkers diagnosed with coronavirus aren't sharing contacts with tracers*, POLITICO, June 16, 2020, https://www.politico.com/states/new-york/albany/story/2020/06/16/most-new-yorkers-diagnosed-with-coronavirus-arent-sharing-contacts-with-tracers-1293254.
[20] Joseph Spector, *New York asking airline passengers to fill out questionnaire as part of COVID-19 quarantine*, LOHUD., June 30, 2020, https://www.lohud.com/story/news/politics/2020/06/30/airline-passengers-new-york-get-covid-19-questionnaire/3284099001/ (quoting New York state health department spokeswoman Jill Montag, "People we have identified from the questionnaires as requiring quarantine will be contacted by Health Department staff and/or contact tracers for follow-up.")

government's plans or help to shape those plans to meet community-identified needs.[21] This is a missed opportunity. Just as community members have been more effective at convincing their neighbors to wear masks and adhere to social distancing,[22] community members and organizations are more likely than outsiders to know how to convince their neighbors to identify their contacts, to get tested, and to self-quarantine when necessary. They are also likely to be more attuned to community-specific needs around stigma and safety – whether regarding sensitive associations or regarding immigration enforcement or over-criminalization.[23] H+H should use this opportunity to learn from the community-based organizations it solicits, rather than simply issuing marching orders. The Community Advisory Board the New York City Department of Health and Mental Hygiene convened offers a similar opportunity.

Second, effective contact tracing requires individuals to share a wealth of intimate information with contact tracers: their location and movements, their health status, and their associations. H+H cannot – and does not – guarantee that contact tracing information will be shielded from law enforcement and immigration authorities. H+H's June 12th T2 webinar made clear that "[a]ny information shared with Test & Trace Corps will not be shared with immigration, law enforcement, or justice officials unless required by law." That "unless required by law" caveat is a big one, and it was repeated on H+H's original "What is Tracing" webpage.[24] H+H's webpage is now silent on whether and in what circumstances contact tracing information will be shared with law enforcement and immigration authorities.[25] If individuals have any reason to believe that sharing the details of their lives will expose them or their loved ones to criminalization or deportation, they simply will not participate.

Fortunately, there is a bill on Governor Cuomo's desk, A. 10500-C/S. 8450-C,[26] that would ensure that law enforcement and immigration enforcement cannot serve as contact tracers or

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[21] *Request for Proposals: T2 Community-Based Organization Engagement Opportunities*, NYC HEALTH + HOSPITALS, July 1, 2020, https://hhinternet.blob.core.windows.net/uploads/2020/07/test-and-trace-community-based-organization-engagement-opportunities.pdf.

[22] Ashley Southall, *Police Face Backlash Over Virus Rules. Enter 'Violence Interrupters.'*, N.Y. TIMES, May 22, 2020, https://www.nytimes.com/2020/05/22/nyregion/Coronavirus-social-distancing-violence-interrupters.html.

[23] *E.g.* Liam Stack & Joseph Goldstein, *New York Threatens Orthodox Jewish Areas With Lockdown Over Virus*, N.Y. TIMES, Sept. 25, 2020, https://www.nytimes.com/2020/09/25/nyregion/coronavirus-orthodox-jewish-communities.html (quoting Avi Greenstein, chief executive of the Boro Park Jewish Community Council, saying, "I have not myself, as the Boro Park Jewish Community Council, been reached out to even once by the city. They're not working properly with this community.").

[24] *What is tracing?*, NYC HEALTH + HOSPITALS, June 12, 2020, https://web.archive.org/web/20200712233232/https://www.nychealthandhospitals.org/test-and-trace/what-to-expect/. (The Internet Archive saves point-in-time snapshots of websites to preserve the history of the internet. *See About the Internet Archive*, INTERNET ARCHIVE, https://archive.org/about/ (last visited Sept. 24, 2020)).

[25] *Tracing: What to Expect*, NYC HEALTH + HOSPITALS, https://www.nychealthandhospitals.org/test-and-trace/what-to-expect/ (last visited Sept. 24, 2020).

[26] A.10500-C/S.8450-C, 2019-2020 Reg. Sess. (N.Y. 2020).

access contact tracing information and that an individual's contact tracing information cannot be used against them in a court or administrative proceeding. The bill would also ensure that contact tracing information will be kept confidential and will only be used for contact tracing purposes, although, importantly, it would permit the use of aggregate, de-identified information to track the spread of the virus and identify disparities among New York communities. City Councilmembers should do everything in their power to urge Governor Cuomo to sign that bill immediately, because information collected to stop a public health emergency has no place in law enforcement or Immigration and Customs Enforcement (ICE) hands.

Finally, on June 17th, the Governor signed a law requiring that contact tracers in New York City be representative of the cultural and linguistic diversity of the communities in which they serve to the greatest extent possible.[27] City councilmembers should ensure that this bill is robustly implemented, including by using their oversight authority to find out whether and how the test and trace corps has changed since the law went into effect and where improvements are still needed.

Contact tracing is too important to get wrong. Ensuring that the T2 program is culturally and linguistically competent and that the contact tracing information collected to mitigate a public health emergency is shielded from law enforcement and ICE are not just privacy and civil rights necessities; they are public health imperatives.

The NYCLU thanks the Committees for the opportunity to provide testimony today and for its consideration of this critically important issue.

[27] A.10447-A/S.8362-A, 2019-2020 Reg. Sess. (N.Y. 2020).

NYLPI
JUSTICE THROUGH COMMUNITY POWER

Testimony of Hayley Gorenberg, Legal Director of New York Lawyers for the Public Interest To the New City Council Committee on Hospitals Jointly with the Committee on Health Regarding the COVID-19 Test and Trace Program (Oversight Hearing 9/30/2020)

To quote our former DOHMH Commissioner Mary Bassett, "Public health has, at its root, the commitment to social justice." New York Lawyers for the Public Interest, where I am Legal Director, has an abiding commitment by mission to our community partners and clients engaged in fighting marginalization based on race and health disparities fueled by systemic racism, all the more clearly a fight for people's lives in the age of COVID-19.

I'll address the City's Test and Trace workforce and the relationship with community-based organizations, key allies in battling the ongoing pandemic.

Strengthening the T2 Workforce

Hiring thousands of New Yorkers as contact tracers was obviously a key to reaching public health goals. It also presented an opportunity to infuse jobs into the communities most ravaged by the paired crises of infection and unemployment.

The brief hiring process, including the switcheroo from DOHMH to H&H, seemed chaotic and pell-mell to meet an opening metric, costing us the potential for higher effectiveness and equity. I emphasize the point because this was not the City's first rodeo and won't be the last. There is a continuing crisis, and there will be more crises, as is always the case in a complicated world. There will be more hiring and opportunities to improve.

New York City inexplicably elevated college degrees and professional public health experience, when the World Health Organization and other authorities make perfectly clear that trusted community connection is the pivotal requirement for successful contact tracing, and specifically flag that degrees are not needed. Some of the communities hardest hit have longstanding, well-known barriers to college education. Prioritizing college degrees and professional experience in this instance undermines public health.

Our community partners specifically elevated concern about the contact tracer qualification in a hearing early in the brief hiring process, I raised it multiple times in meetings with the DOHMH

Emergency Partner Engagement Council, and NYLPI set forth detailed questions and critiques of the posting in our letter to numerous City officials during the hiring process, which I will include with my written testimony.

NYLPI presented our survey of every set of qualifications for contact tracers we could find in job postings in fifteen jurisdictions around the country, including New York State's qualifications -- starkly contrasting with New York City's. The points went unaddressed throughout the brief and intense hiring period, though one official opined that the City ought not be questioned, because it had hired tracers for other public health reasons before, so knew what it was doing. But relying on old systems runs the risk of neglecting modern approaches to HR and discounts entrenched bias that may pervade hiring systems. Finally, subsequently, and in stark contrast, officials helping run the T2 program later distanced themselves from the posting and said they didn't know how it had come to exist.

We know public health efforts must address "educated mistrust" of the health establishment in Black and brown communities, based on historic abuses. And we know from Dr. Long that seven months into the pandemic, we're falling short of linguistic goals and of the stated public health goal of interviewing 75% of identified contacts. Anything that unjustifiably screens out people from communities most engaged in the fight against marginalization demands prioritized scrutiny and critique, because it directly impacts public health goals, and because it stands in the way of an equitable shot at jobs to the communities that need them most, which also connects to community health and wellbeing.

The job specifications are important for at least two major reasons:

1. First, contact tracing relies on the ability to develop strong, trusting relationships, and I cannot count the number of times those of us meeting with City health representatives have reiterated that succeeding on the public health front absolutely requires trusted messengers and community members to do this work. They are the vital core.
2. Second, if the City had strongly prioritized hiring from the hardest-hit communities, including by eliminating barriers in the job posting, it would have infused many more jobs directly into the New York City economy in communities most in need of them. That economic lifeline links to the health and wellbeing of individuals, their families, and entire communities. We could have better served both critical needs. It was a big, quickly moving opportunity – and in important ways, it was missed.

Also, additional hires of T2 monitors have been made through Optum, rather than Health and Hospitals. Our understanding on the Community Advisory Board workforce working group is that there had been at least some idea of rolling those hires into H&H, with attendant benefits, union representation, etc. Our further understanding is that it hasn't happened, and we have not received answers or a timeline for answers. Supporting the workforce with high-quality jobs directly benefits workers, of course. But the benefits also flow to families and communities where workers live and where they serve people who need their help. In addition to job quality, we have questions about information Optum workers get. For example, regardless of whether

they are H&H or Optum, could they all get City communications on accessing flu vaccines for themselves, including most affordable options?

NYLPI urges that the City take the following steps:

1. Overhaul all its hiring rubrics to ensure that job qualifications match lockstep with job descriptions of what's to be done, to avoid excluding people who can do a job well. Searching review is particularly important to ensure that traditional frameworks don't carry forward systemic racism and other biases.
2. Assess the City's assertion, made as a purported sign of success, that more than half of the tracers were hired from hardest-hit communities, addressing the following points:
    a. Why is hiring more than half the tracers from these communities considered successful? Why shouldn't a successful figure be closer to 100 percent? What is the City's benchmark? Especially when we're significantly below public health goals on contact interviews completed, stating that about half of the tracers are from hardest hit communities seems of ongoing great concern.
    b. Release additional data probing truly successful tracing and community support, going well beyond the question of whether at least one contact is reported or interviewed per tracing effort. Pull out the stops to deeply assess effectiveness in tracing, including range of contacts provided and barriers (including but not limited to language), turnaround time for effective services, and connecting people to resources they need to keep themselves and those around them as safe and supported as possible.
    c. Release full data on the contact tracer applicant pool and hires, including how many contact tracer applicants and how many hires had bachelor's degrees, throughout all program positions. Do the same with regard to professional health experience. Correlate to race and ethnicity.
    d. Release data illuminating the qualifications of those who stay and those who leave the Test and Trace staff. How many have bachelor's degrees, and how many don't? How many have professional public health experience, and how many don't? Assess for correlations to inform the ability to succeed in the work going forward. Again, one can be a big proponent of education and still acknowledge that a strong fit for the job is vital to success. (See article on master's degree quit.)
3. Conduct any additional T2 hiring using sound guidelines such as those from the WHO as a guiding star, prioritizing hiring from the most directly affected communities – for maximum effectiveness and equity.
4. Thoroughly inquire into the H&H/Optum split of jobs in the T2 program, shedding light on what the plans and opportunities are, going forward, for best-quality jobs and health-related communications possible.
5. Make sure outreach for further hiring includes highly effective partnership with community organizations.

Strengthening Community Engagement

The need for highly effective community partnerships leads to my other area of focus today: relationships with New York City's extensive, talented and effective community-based organizations.

Early in the pandemic the City reached out to community organizations to form the Emergency Partner Engagement Council's working groups and the T2 Community Advisory Board and its working groups. Great idea. Keep it up. Make it more functional, more connected, more effective.

Here are some ideas about how that can happen:

- Eliminate or coordinate overlap. For example, EPEC and the T2 CAB both have messaging working groups. Despite inquiries, it is unclear to us how it makes sense to have two messaging groups, whether there is any functional demarcation in the work, and whether the work of the two groups is being compared, contrasted or synergized.
- Ensure the work product of community members and organizations in these groups is seen, assessed, and incorporated as is useful – and let us know, clearly and in a timely fashion, that it's being used. Or ask us for something different. It too often feels like we're pitching into the void, no matter how productive the discussions are in the moment.
- Address staff turnover and rotation. City staff facilitators for our working groups switch out every few weeks. We are constantly working to re-establish relationships. The folks who facilitate seem dedicated and concerned -- and then they're gone. It's a constant parade of apparently well-meaning people. Especially when we're already having questions about where our suggestions, feedback and work product go, the perpetual meet-and-greet further undermines our effectiveness.

We've been straightforward about these concerns, and relatedly, about reporting to our organizations about what we're doing and its worth, bang for the staff-time buck, and about wanting to make sure we are never a community engagement "box-check" in the system. To be most helpful, we want to take full advantage of the potential to engage with the government to do public health good, and we want the system to use our talents well. We can't afford to spend our time in multiple meetings saying the same thing with no assurance that it has been meaningfully considered for impact. For example, one group raised ideas about meshing flu vaccine access and COVID testing, and we did not timely know whether the idea was absorbed, rejected, duplicative, delayed or lost. There is some growing suspicion that to really get things done we need to call our own side meetings, rather than use the structures and staff provided.

I will say that the T2 CAB has benefited from some truly excellent presentations, complete with useful slides we can share with the community and engagement on the spot with our questions. Continuing these strong contributions means a great deal. We request presentations and get them. Slide decks are often excellent. My sense is that many committed staff are applying great talents and are willing to acknowledge when the system falls short and consider changes. I was encouraged to hear yesterday evening that more of a loop-closing mechanism to give us answers to questions and prioritize our recommendations is being devised. Of course tomorrow it's

October, and we've been asking for a long time. Going forward, we urge that efficiently incorporating the community's best ideas be structured in from the outset, as a critical component to the City's health and success.

Thank you.

Hayley Gorenberg
Legal Director
New York Lawyers for the Public Interest
151 West 30th Street, 11th floor
New York, NY 10001
hgorenberg@nylpi.org
212.336.9322 (direct)

Since 1976 New York Lawyers for the Public Interest (NYLPI) has been a leading civil rights and legal services advocate for New Yorkers opposing marginalization on the basis of race, poverty, disability, and immigration status. Our community-driven work integrates the power of individual legal services, impact litigation, and comprehensive organizing and policy campaigns. Guided by the priorities of our communities, we strive to create equal access to health care, achieve equality of opportunity and self-determination for people with disabilities, ensure immigrant opportunity, strengthen local nonprofits, and secure environmental justice for low-income communities of color. For more information, please visit www.nylpi.org.

NYLPI
JUSTICE THROUGH COMMUNITY POWER

New York Lawyers
for the Public Interest, Inc.
151 West 30th Street, 11th Floor
New York, NY 10001-4017

May 29, 2020

Dear Speaker Corey Johnson, Health and Hospitals Corporation President and CEO Mitchell Katz, Councilmember Carlina Rivera, Councilmember Mark Levine, Councilmember Daneek Miller, Councilmember Adrienne Adams, Councilmember Francisco Moya, Councilmember Farah Louis, First Lady Chirlane McCray, Deputy Mayor J. Phillip Thompson, Mayor Bill de Blasio, Deputy Mayor for Health and Human Services Raul Perea-Henze, Senator Gustavo Rivera, and Assembly Member Richard Gottfried,

With appreciation for the opportunity to participate in the Emergency Partner Engagement Council COVID-19 working group these past two weeks, I write on behalf of New York Lawyers for the Public Interest and our community partners to pursue the answer to a question I've been raising consistently in the meetings regarding the stated qualifications for hiring a cadre of New York City contact tracers to assist in addressing the spread of the novel coronavirus. The question is time-sensitive, with much hiring already reported as accomplished; a response was indicated forthcoming, but unfortunately, there's been no response to date. Nonetheless, as hiring will continue, we're escalating the inquiry.

Specifically, NYLPI seeks the specific rationale for prioritizing that New York City's contact tracers have college and substantial health/science experience. Further, if the rationale for requiring the qualifications currently in force does not comport with the actual, functional requirements for performing the job of contact tracing, NYLPI seeks a modification of the qualifications, to increase the likelihood that remaining jobs will go to members of New York City communities most deeply affected by COVID-19.

The racial disparities in novel coronavirus impacts, including the devastating impact in low-income Black and Latinx communities, indicates that contact tracers will be in great need in these communities. To be effective, contact tracing requires building rapport and trust. Community members may be particularly well-qualified to connect and succeed in the contact tracing role. At the same time, college and professional public health and science experience are often qualifications less widely available to members of low-income communities of color that have been historically fighting marginalization.

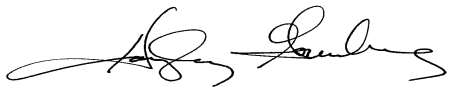
It is axiomatic that addressing challenges to racial diversity, equity and inclusion within the context of historical systemic racism requires assessing job qualifications to weed out any unnecessary "pedigree"-type qualifications that may pose barriers to employment if they are not actually required in order to do the job.

With these concerns in mind, **New York Lawyers for the Public Interest assessed COVID-19 contact tracing hiring information available in fifteen jurisdictions around the country where we could find postings for the positions** (table attached). **We found that New York City had the most restrictive job requirements for contact tracers, with the most extensive educational and experiential requirements.**

Hiring contact tracers means injecting jobs into a City starved for them. Both equity and public health effectiveness support making those jobs as available as possible to members of communities hardest hit by COVID-19.

For the above reasons, we look forward to receiving a clear explanation of the City's hiring approach for contact tracers, and if merited based on the above, an equitable change in any hiring going forward. Thank you.

Sincerely,



Hayley Gorenberg

Legal Director

Job Title and Location	Job Duties	Educational Requirements	Experiential Requirements
Contact Tracer I and II (NYC)	• Conducts telephone calls with individuals diagnosed with COVID in order to "elicit and trace" others exposed to COVID. • Provides follow-up instructions to those with COVID or those who had contact with someone COVID positive. These instructions relate to isolation/quarantine, monitoring, assessing need for medical care or supportive services. • Follows up with cases and contacts. • Can refer individuals for COVID testing "if appropriate." • Collects and records information into the data system. • Records data entries promptly. • Follows approved scripts and protocols. • Provides information about social and health resources based on approved scripts and lists. • Maintains daily communication with Supervising Contact Tracer. • Escalates cases to supervisor when "appropriate." • Needs to be able to communicate "in a professional and empathetic manner."	• A "baccalaureate degree" from an accredited college or university including or supplemented by twelve semester credits in health education, or in health, social, or biological sciences. • Or four-year high school diploma or its educational equivalent approved by a State's Department of Education or a recognized accrediting organization. • Or a combination of education and experience. Undergraduate college credit can be substituted for experience. It is 30 semester credits from unaccredited college is equal to one year of experience. • All candidates must have a four-year high school degree or equivalent.	• "Satisfactory completion" of the online COVID-19 Contract Tracing Program. • If applicant has a BA, must have six months of full-time "satisfactory experience" in a health promotion or disease intervention/prevention program where they performed one or more of the following: interviewing, conducting field investigations, assessing health risks, making referrals, or collecting and analyzing epidemiological data. • If a four-year high school diploma or equivalent, four years of full-time "satisfactory experience" in a health promotion or disease intervention/prevention program where they performed one or more of the following: interviewing, conducting field investigations, assessing health risks, making referrals, or collecting and analyzing epidemiological data. • All candidates must have either 12 semester credits in health education, or in health, social, or biological sciences, or the six months of experience with the health promotion or disease intervention/prevention programs described in the above bullets. For Level II: • Must have one year of experience as Public Health

	• Needs to be able to communicate and demonstrate awareness of "diverse health-related needs" • Needs to be able to protect and maintain individuals' privacy and confidentiality. • Recognize, document, and alert supervisor of trends in customer calls. • Checks records to ensure they are accurate and that the information conforms with policies. • Conducts in-person investigations into congregate settings or other cases.		Adviser or at least one additional year of experience with the health promotion or disease intervention/prevention programs described in the above bullets.
Contact Tracer (NYS)	• Collaborate with the Case Investigator from the local health department. • Call the contacts of newly diagnosed COVID cases. • Communicate with contacts in a professional and empathetic manner. • Provide contacts with approved information about NYS isolation or quarantine and what to do if they develop symptoms. • Follow a set script to provide contacts with this information. • Maintain daily contact with Team Supervisor.	• High school diploma or equivalent required. • "Some college training preferred."	• No experiential requirements listed.
Contact Tracer (Chicago)	• Calling close contacts of newly diagnosed COVID cases and communicating further	• Bachelor's Degree is preferred but not required. • High School diploma/GED required	• 1-2 years of customer service experience • Public or private healthcare experience is a plus but not

	actions to those individuals. • Collection and recording highly sensitive information into a secure web-based CRM. • Following approved call scripts to collect and share information while adhering with policies and procedures. • Providing those contacted with approved quarantine procedure information. • If appropriate, making a resource referral.		required (want people with HIPAA knowledge) • Bilingual is strongly preferred
Contact Tracer (Louisiana)	• Interview and advise people who have tested positive to determine who could be at risk.	• Must have graduated high school	• No experiential requirements listed. • Must be comfortable having telephone conversations and entering data.
Contact Tracer (Massachusetts)	• Call contacts of newly diagnosed patients. • Communicate in a professional and empathetic manner. • Collect and record information on symptoms into the CRM. • Provide contacts with approved information about MA quarantine procedures. • Refer contacts to testing of appropriate according to protocol. • Follow script to inform contacts about quarantine and what to do if symptoms develop. Not permitted to deviate from the script. • Maintain daily contact with supervisor.	• High school diploma or equivalency required. .	• None listed, but must own a computer (iPads are insufficient)

Temporary Contact Tracer (San Diego)	• Identify potential close contacts of confirmed COVID cases • Notify contacts and promote self-monitoring • Ensure contacts who develop symptoms isolate and notify public health staff • Refer contacts to healthcare provider for medical advice, testing and care.	None listed	None listed
COVID Tracer (New Jersey)	• Call contacts of newly diagnosed patients • Collect and record information on symptoms into CRM. • Provide contacts with the approved information about NJ quarantine. • Refer contacts to testing or to COVID Care Resource Coordinator according to protocol if appropriate. • Follow the script to inform contacts. • Maintain daily contact with supervisor.	• High school diploma or equivalent	None listed
Contact Tracer (Georgia)	• Call every case and either call or monitor every contact of anyone diagnosed with COVID. • Refer contacts to testing according to protocols. • Provide contacts with instructions on quarantine. • Must follow all scripts, policies, and procedures provided by the Department of Public Health.	• High school diploma is required. • Bachelor's degree or current college (undergrad or grad) student majoring in Public Health (or a recent graduate) are <u>preferred.</u>	• None, but do have a preference for those who have completed coursework in epidemiology.

	• Conduct interviews and document interviews in a digital system.		
Contact Tracer Part-Time (Texas)	• Call contacts of anyone diagnosed with COVID. Document a symptom check of the contacts, and refer them for testing in accordance with protocols and provide them with instructions on quarantine. • Collects and records information on symptoms into Texas Health Trace. • Follows a script to inform contacts. • Maintains daily contact with supervisor.	• High school diploma or equivalent. • Bachelor's degree in a related field from accredited university is preferred. • Completion of coursework in epidemiology is preferred.	• Experience in customer service or public facing position. • Experience in Public Health, medical or related field is preferred.
Contact Tracer (Houston, TX)	• Call contacts of newly diagnosed patients. • Collect and record information into the reporting system, CRP, as well as the surveillance and management system. • Provide contacts with approved information about quarantine procedures and refer them to testing or resources if appropriate. • Follows the script to inform contacts about the importance of quarantine and what to do if develop symptoms. • Maintain daily communication with supervisor. • Manage calls, email, and/or interactive voice response system.	• High school diploma or equivalent and some college level coursework completed. • Bachelor's Degree is preferred.	• None listed.
COVID Contact Tracer (Connecticut)	• Use CRM to coordinate services needed by	• High school diploma or equivalent.	• Experience in social work or public health is preferred but not required.

	COVID cases and contacts. • Coordinate grocery and prescription delivery. • Locate resources. • Manage referrals in the "local area." • Perform other duties assigned/necessary.		• Computer proficiency required.
Contact Tracer I (Kentucky)	• Use CRM to coordinate services needed by COVID cases and contacts. • Coordinate grocery and prescription delivery. • Locate resources. • Manage referrals in the "local area." • Perform other duties assigned/necessary.	• High school diploma or equivalent.	• Experience in social work or public health is preferred.
Contact Tracer II (Kentucky)	• Notify exposed individuals of potential exposure. • Provide contacts with education, information, and support. • Encourage contacts to stay home and social distance. • Check in with contacts to make sure self-monitoring and not symptomatic. • Maintain data in contact tracing software.	• High school diploma or equivalent.	• Experience with social work or public health is preferred but not required.
Covid-19 Contact Tracer (Kentucky)	• Use CRM to call all contacts of anyone diagnosed with COVID-19. • Document a symptom check of the contacts and refer them to testing according to policy and provide them with instruction on quarantine.	• High school diploma or equivalent.	• Experience in clinical medicine or public health is preferred but not required. • Strong preference for nurses or other clinical staff.

	• Follow all scripts, policies, and procedures.		
Contact Tracer (St. Louis, MO)	• Follow all scripts, policies, and procedures. • Call and communicate with contacts of COVID patients. • Provide contacts with approved information about quarantine, resources, and testing. • Record collected information in the online CRM. • Maintain daily communication with supervisor.	• High school diploma or equivalent.	• Experience related to the position and understanding of health and disease is preferred but not required.

Testimony of the New York Immigration Coalition
Joint Oversight Hearing of the Committees on Hospitals and Health
NYC's COVID-19 Testing and Contact Tracing Program, Part II

Max W. Hadler, MPH, MA

September 30, 2020

My name is Max Hadler and I am the Director of Health Policy at the New York Immigration Coalition (NYIC). The NYIC is an advocacy and policy umbrella organization for more than 200 multi-ethnic, multi-racial, and multi-sector groups across the state working with immigrants and refugees. Thank you to Committee Chairs Carlina Rivera and Mark Levine, and all members of the Committees on Hospitals and Health, for the opportunity to submit this testimony.

The NYIC has been involved in many aspects of the Test & Trace effort to date – we are a contracted outreach partner, we are designing a training for contact tracers on immigrant New Yorkers' health access and public charge concerns, and we are a member of the Community Advisory Board (CAB) and several of its workgroups. We applaud Test & Trace for establishing the CAB and for contracting with community-based organizations (CBOs) to support outreach and resource navigation. We also have remaining concerns to share with the Council as we navigate the current situation of low transmission, schools in the process of reopening for in-person learning, and the ramp-up of flu season.

The Department of Health and Mental Hygiene (DOHMH) has led the CAB process and helped to allay some of the concerns and confusion that emerged from the Mayor's decision to strip the contact tracing effort from DOHMH's control. However, there is still a lack of clarity on where different responsibilities lie, which is now a major concern in the school reopening process. While the CAB has had meaningful input on several aspects of Test & Trace, testing and tracing in the context of school reopening has not been a significant source of discussion and we are unaware of other community-oriented advisory processes informing reopening. The seemingly haphazard creation of a "situation room" has further added to confusion and we are unclear on how to engage in the process and provide input into the testing and tracing scheme for schools. The rapid pace of change is particularly difficult to navigate for immigrant and limited English proficient (LEP) families and would be better served by having a clearer accountability and feedback mechanism that involves education advocates working specifically with immigrant families.

On data privacy, we appreciate the creation of a CAB workgroup specifically on this issue and Test & Trace staff's work to improve its core message around data protection, but we would still like to see stronger public support from the City to urge the governor to sign into law the Contact Tracing Confidentiality bill (A.10500-C/S.8450-C) that would further protect the data of concerned New Yorkers. There is also new data security-related uncertainty around the state's launch of the COVID Alert NY app. While we are currently in the process of understanding the security of the app, and acknowledge that it is an opt-in voluntary add-on to existing efforts, we are also concerned about the possibility that the app will deepen inequities if it in any way sidetracks or diverts resources or time that are not readily accessible to all regardless of the language they speak or their access to smartphones or other app-enabled devices. It is worth noting that the City's language access laws are more expansive than the State's, so the City should undertake a

New York Immigration Coalition
131 W 33rd St. Fl 6
New York, NY 10001
212 627 2227
nyic.org

City-specific language access evaluation to be able to equitably use State-created apps or tools, in addition to considering how disparate tech access to app-enabled devices might deepen inequities.

Overall, we must remember that the underlying conditions that have caused immigrant New Yorkers to be disproportionately affected by COVID-19 remain in place – immigrants represent more than half of NYC's essential workforce (signifying greater exposure); undocumented and mixed-status families have been excluded from federal relief programs; and many immigrant New Yorkers continue to suffer reduced access to health services during the pandemic because of the state's persistent health insurance discrimination against those without status. An equitable approach to Test & Trace must account for these disadvantages by putting these communities at the forefront of planning for all subsequent stages of the pandemic, including future increases in transmission and the eventual distribution of vaccines. This includes making sure that any prioritizing of so-called "essential" workers includes people who are often not part of the popular imagination of "essential" and who are disproportionately immigrant workers in food service and the informal sector, among others. It also means developing a strong focus on communications for people who are LEP from the outset.

We look forward to continuing to work with the Council and the Administration on all of these issues. Thank you for the opportunity to testify today.

NEW YORK DOCTORS COALITION | T3 EQUITY SUBCOMMITTEE

TESTIMONY FOR THE NEW YORK CITY COUNCIL COMMITTEES ON HEALTH AND HOSPITAL ON THE SEPTEMBER 30TH CONTACT TRACING EQUITY HEARING

I. Persistent Inequity in Testing

In March, we proposed the concept of pandemic "hot zones" based on the regional disparity in case rates and death rates at the time.[1] NYC zip codes with transmission rates near or above 3% deserve high priority for SARS-CoV2 PCR or rapid testing and contact tracing resources. This is because 3% has been proposed by the Harvard Global Health Institute[2] as a COVID-19 test positivity rate that is consistent with appropriate access to testing (i.e., testing enough people that few of them test positive and nearly all cases are detected). However, until there is widespread vaccination, the former hot zones are the most likely to experience disproportionate suffering and death from a second wave of infections. The social determinants of health that led to this disparity will remain risk factors for harm from COVID-19. Thus, the hot zone areas by the March definition (zip codes with death rates of 500 or higher per 100,000 population or zip codes with case rates about 3,500 or higher per 100,000 population: East New York, Canarsie-Flatlands, Rockaway, and Coney Island in Brooklyn; Northeast Bronx, Pelham, Morrisania, Kingsbridge, and Fordham in the Bronx; and West Queens, Elmhurst, Flushing, and Jackson Heights in Queens) continue to require intensive test, trace, and take care (T3) resources to mitigate the health inequities highlighted during the first surge. Therefore, we recommend focusing T3 resources on the original hot zone zip codes, in addition to those with COVID-19 test positivity rate of above 3%. We maintain that the areas hit hardest in March and April remain at highest risk for COVID-19 morbidity and mortality due to racism, chronic disadvantage, and underinvestment.

II. NYC DOHMH's Involvement in Past and Current Pandemic Prevention/Preparation

In March, the NYC Department of Health and Mental Hygiene (DOHMH) was involved in setting up the alternate care site at the Billie Jean King National Tennis Center (BJK); it also helped organize discharge planning strategy for the state at the Javits Center facility. Initially patients were discharged to the street with little to no follow up. DOHMH also helped organize the deployment of 13,000 volunteer medical reserve staff. Ultimately, we know that the alternate care sites were underutilized, with the BJK costing 52 million to set up while treating only 79 patients even while they were fully staffed.[5] This raises troubling issues regarding the City's initial response. Specifically, the DOHMH should explain the decision to devote resources – including volunteer medical staff – to alternate care sites rather than expanding existing hospitals. The process for furloughing staff from Federally Qualified Health Centers (FQHCs) while relying on volunteers and, eventually, new hires to staff contact tracing efforts also deserves explanation, since FQHC staff would be expected to have existing relationships with their community to facilitate trust in contact tracing.

When NYC Health and Hospitals (H+H) took over contact tracing from DOHMH, they lacked statutory authority to collect information on public health information.[6] Only DOHMH has the authority to get this data from hospitals across the city. A memorandum of understanding facilitated the transfer of jurisdiction from DOHMH and H+H, along with over 100 staff. However, H+H is still running into problems related to lack of jurisdiction, including delays in the collection of COVID-19 information from hospitals to facilitate contact tracing. Given DOHMH statutory authority in public health disease surveillance and extensive experience in population medicine, why was jurisdiction over contact tracing

transferred to H+H? While H+H does have a larger administrative staff than DOHMH and, being a public corporation, have greater flexibility to subcontract, it is understandable that their involvement could be valuable. However, H+H could have been brought on as a partner under the direction of the DOHMH, instead of relying on a subset of DOHMH staff to manage and train a larger force of contact tracers hired through Optum, exposing itself to potential conflicts of interest in the process. Of note on this issue, other states (including Massachusetts) have successfully scaled up contact tracing through partnering with the private sector without circumventing the authority of the state department of health.

III. Inequality in Isolation Options and Treatment Access

As Governor Cuomo congratulated his constituents about bending the curve and preserving the healthcare infrastructure, the unmentioned cost was a record shattering death toll. Over two months in Spring, NYC's COVID-19 death toll (over 20,000) [7] exceeded that of the 1918 influenza outbreak during a similar timeframe.[8] The preservation of infrastructure came at the expense of human lives.
According to data from the New York City Department of Health and Mental Hygiene, only around 26 percent of COVID-19 patients were hospitalized at the peak of the initial surge in early April.[9] In late April, many patients symptomatic with COVID-19, particularly people of color in NYC outer boroughs, were not admitted even when they test positive. This included many among the elderly frail, and those experiencing long standing health inequity due to racism, who are at elevated risk of dying, but did not show a low oxygen saturation level at the time of presentation. Stringent admission criteria is a holdover from pre-pandemic practices.

We now know that treatment outcomes across city hospitals were highly unequal during the initial surge.[14] To cite a well-known example with which some of us have first-hand experience, during the fourth week of March, healthcare workers at Elmhurst Hospital Center were caught off guard by a deluge of patients.[15] A hundred ventilated patients waited in the ED for beds to open up in this 550-bed hospital, sometimes with a single nurse to look after a dozen patients at a time. Sedatives ran out, as did other critical drugs like vasopressors and analgesics. By early April, Federal Emergency Management Agency (FEMA) descended on Elmhurst to provide ventilators and support staff. Patients should have been immediately transferred out to facilities like the USNS Comfort and the Javits Center, but their egress was impeded by a hyper-selective 49-item criteria that initially excluded patients with COVID-19.[16] There was moreover no process in place to transfer patients to hospitals in Manhattan that still had supplies and staff to spare. But there is a huge problem with hospitalizing the bare minimum in the midst of a pandemic, one not limited to the individual lives at stake. Sending patients back into the community assumes from the outset that hospitals have no role in interrupting the virus's chain of transmission. Because a negative COVID-19 test was not necessary for discharge in New York, many patients leaving the hospital return to endanger those close to them in their community, with devastating consequences in nursing homes and low income communities of color.[17]

These are mistakes that we can learn from as we approach a probable and imminent second surge. First, with a clearer sense of the biological and social determinants of morbidity and mortality from COVID-19, screening criteria for recommending admission and follow-up can be more targeted to those who can benefit the most. While the specific terms of the admission criteria require a thorough review of the literature, this process should overall result in lowering the threshold for admitting patients for COVID-19 in comparison to the relatively high threshold for admission in March and April, particularly, taking into account racism as a risk factor. Second, existing hospital facilities, especially chronically

underfunded and understaffed “safety net” hospitals, require disproportionately more support from state and city agencies. The needs of existing acute care facilities, including beds that could be opened up in overflow areas, should take priority over alternate care sites. If alternate care sites are to be utilized, they may be better suited as sites for isolation under monitoring for asymptomatic or minimally symptomatic individuals. It thus stands to reason that a moratorium on the closure of existing inpatient acute care facilities (such as Kingsbrook Jewish Medical Center) would be imperative.

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TESTIMONY: UJA-FEDERATION OF NEW YORK

New York City Council Committee on General Welfare
Oversight: NYC's Covid-19 Testing and Contact Tracing Program, Part II

Submitted by:
Ariel Savransky
UJA-Federation of New York

September 30, 2020

Thank you to Chairperson Rivera and Chairperson Levine and members of the Council Committees on Health and Hospitals for the opportunity to submit testimony on NYC's Covid-19 Testing and Contact Tracing Program. My name is Ariel Savransky and I am an advocacy and policy advisor at UJA-Federation of New York.

Established more than 100 years ago, UJA-Federation of New York is one of the nation's largest local philanthropies. Central to UJA's mission is to care for those in need. UJA identifies and meet the needs of New Yorkers of all backgrounds and Jews everywhere. UJA connects people to their communities and respond to crises in New York, Israel and around the world, and supports nearly 100 nonprofit organizations serving those that are most vulnerable and in need of programs and services.

Thank you to the city for bringing together the Test and Trace Corps to fight Covid-19 so that NYC can safely reopen and for inviting UJA to be a participating member of the T2 Community Advisory Board. UJA appreciates the city's commitment to provide New Yorkers with the resources needed to navigate this process. UJA submits the following recommendations to ensure that all communities are protected and are receiving the appropriate resources and recommendations throughout this process:

1. **Engage community-based organizations (CBOs) and faith partners in developing communications campaigns and overall field outreach strategy through the Test2 Community Advisory Board and Test and Trace Corps**
    a. These organizations and faith leaders have in-depth knowledge of the communities in which they work and are trusted leaders—an asset to be used in understanding how to engage with community members. CBOs and faith partners in these communities are familiar with these existing nuances. In developing overall outreach strategies and messaging, UJA urges the Council and the Administration to tap into the knowledge base of these CBOs and faith leaders in both developing messaging as well as deciding how to disseminate information to different communities. This will result in increased engagement by community members in efforts put forth by the city to stem outbreaks, such as mask compliance, social distancing and contact tracing.

    Additionally, UJA would like to thank the T2 Corps for efforts to recruit staff from within communities so that trusted voices are spreading the message on the ground. UJA looks forward to continuing to work in partnership with the city to spread these opportunities widely with the community-based agencies with which we work.
2. **Ensure that all Test and Trace materials are translated into appropriate languages**
    a. All New York City agencies are required to create a Language Access Implementation Plan to ensure access to their services for limited English proficient individuals. Local Law 30 of 2017 strengthened language access services for individuals by expanding the list of designated citywide languages to 10. UJA urges the Council and the Administration to ensure that all outreach materials are translated into, at minimum, these 10 languages. Additionally, UJA urges the Council and Administration to go further and communicate directly with those in hard-to-count neighborhoods to expand existing translation. CBOs and faith partners can be

resources in these efforts, ensuring that all messaging is translated into the appropriate language for their communities.

3. **Ensure that community-based organizations and faith partners are involved in educational engagement and strategy conversations in real-time as Covid-19 clusters arise in specific zip codes throughout the city. Develop clear and concise guidance in what will trigger closures and what the contact tracing process will entail.**
    a. UJA urges the Council and the Administration to think creatively about ways to open communication between the City and faith and CBO partners to help direct resources to the communities that are seeing rapid increases in Covid-19 cases in real time. Engaging these entities will serve to strengthen the relationship between the city and community partners and will ensure that the messaging to that community is both appropriate and coming from a trusted source. Working with community leaders will help the city to understand faith-based observances and religious practices as well, which will dictate appropriate timing of messaging. For example, during this high holiday season, there are days of strict religious observance where efforts to conduct outreach by the city on these days will be interpreted negatively by the communities that are being targeted. Furthermore, this engagement will help to dispel misinformation that may be coming into specific communities by providing these leaders with the facts which can then be communicated to their communities.

    Additionally, as CBOs and faith leaders engage in these efforts, it is crucial that the directives coming down from the city clearly lay out what will trigger closures and what the contact tracing efforts will look like. This is particularly relevant in the private schools with which UJA works. Presenting a unified message with clear guidance will ensure that schools are able to follow closure protocol and are aware of the information needed to ensure effective contact tracing.

Thank you for the opportunity to testify We look forward to working closely with the Council and the Administration to reach all New York City communities. Please contact Ariel Savransky at savranskya@ujafedny.org or 212-836-1360 with any questions.