CITY COUNCIL
CITY OF NEW YORK

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TRANSCRIPT OF THE MINUTES

Of the

COMMITTEE ON WOMEN AND GENDER EQUITY
JOINTLY WITH COMMITTEE ON HEALTH

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February 14, 2024
Start: 10:15 a.m.
Recess: 11:54 a.m.

HELD AT: COUNCIL CHAMBERS – CITY HALL

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Lynn C. Schulman, Chairperson of the Committee on Health

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SERGEANT-AT-ARMS: This is a microphone check for the Committee on Women and Gender Equity joint with the Committee on Health, recorded on February 14, 2024. Recorded by Nazly Paytuvi in the Chambers.

SERGEANT-AT-ARMS: Good morning and welcome to the Committee on Women and Gender Equity jointly with Health.

At this time, we ask if you could please place phones on vibrate or silent mode.

Chairs, we are ready to begin.

CO-CHAIRPERSON LOUIS: [GAVEL] Good morning and Happy Valentine's Day.

I am Council Member Farrah Louis, Chair on the Committee on Women and Gender Equity, and I'd like to welcome everyone to our joint oversight hearing with the Committee on Health addressing disparities in women's health.

I'd like to thank my phenomenal Colleague and Chair on the Committee on Health, Council Member Lynn Schulman, for her partnership to hold this important hearing today.

Gender biases in healthcare is a prevalent and extensively reported problem that often

results in unfavorable experiences and adverse outcomes for women in our city, particularly women of color. The International Journal for Equity in Health reports on the underlying myth that bodies assigned male at birth are somehow superior to those assigned female at birth. In addition, such myths about biological sex are also those around race, which inaccurately ascribe physical, mental, and emotional qualities to individuals based on race. This misconception has substantial effects, consequences, and ramifications for girls and women of all ages, including significant gaps in medical and clinical research, insufficient testing, misguided diagnosis, and even inaccurate treatment plans. In addition, misconceptions around women's sensitivity to pain and exacerbating pain persists, even among non-male physicians, and, as we observe Black History Month, I would be remiss if I did not highlight that studies show that black women have reportedly been routinely taken less seriously in healthcare spaces by their physicians than their white counterparts. Therefore, much less likely to trust healthcare providers. Biases in healthcare provision not only perpetuate harmful stereotypes, but also result in women and

gender-expansive people avoiding medical care or receiving inadequate care which further negatively impacts their health outcomes.

Ongoing implicit bias and racial disparities in healthcare in New York City are alarming and, as a black woman, I am deeply concerned about this particular issue. We must recognize that while we'll highlight and draw attention to gender inequities in this hearing, many of the challenges that women face will persist until we take aggressive and effective action to address them.

Today, we'll be taking a broad look into the leading causes of death among women in the United States and in New York City, which include cardiovascular disease, cancer, chronic lower respiratory disease, and Alzheimer's disease. We look forward to hearing more about the leading health issues facing women in New York City and the disparities and challenges that women experience accessing preventative healthcare services.

I would like to thank the representatives from the Department of Health and Mental Hygiene, advocates, and members of the public who have joined us today. I would also like to thank my Staff, Blake

Shaw, Phil Marius, Daniel Heredia as well as Committee Staff, Committee Counsel Sahar Moazami and Senior Legislative Policy Analyst Cristy Dwyer for their tireless work on this hearing.

Now I'd like to turn it over to my Colleague, Chair Schulman, for her opening remarks.

CO-CHAIRPERSON SCHULMAN: Thank you, Chair Louis. Before I begin, I want to acknowledge that we've been joined by Council Members Menin, Narcisse, Marmorato, and Vernikov.

Good morning, everyone. I am Council Member Lynn Schulman, Chair of the New York City Council's Committee on Health. I want to thank Chair Louis and the Committee on Women and Gender Equity for joining with me for this important hearing today. Today is Valentine's Day, and there is no day more appropriate to focus on matters of the heart, and more specifically, heart health. The Committees today are shining a light on the most urgent health issues facing women in New York City and in the United States including heart disease, which according to the CDC, is the number one health issue facing women in our country. We also hope to discuss any efforts the City is undertaking to address the disparities

that women face in the areas of cancer care, chronic lower respiratory disease, and Alzheimer's, all leading causes of death for women in the United States and among the leading causes of death for women in New York City.

Persistent gender bias in healthcare has resulted in inadequate access and treatment for women across the country. Studies have consistently found that some healthcare professionals continue to view women as emotional or hysterical and are more likely to attribute their symptoms to a mental health condition rather than a physical condition. Misconceptions around women exaggerating pain persist to this day, even among non-male physicians. Biases in healthcare provision not only perpetuate harmful stereotypes but also result in women avoiding medical care or receiving inadequate care that negatively impacts their health outcomes. As a breast cancer survivor and as Chair of the Committee on Health, I am committed to ensuring that every woman in New York City has access to quality preventive care including regular screenings.

Healthcare is a human right and the City must work with our state and federal partners,

healthcare providers, community organizations, and advocates to eliminate disparities among women when it comes to identifying, diagnosing, and treating cancer. Social, environmental, and economic burdens contribute to the wide gaps in cancer outcomes for women as compared to men and for non-white women as compared to white women. For example, in 2021, the rate of premature death from cancer was about 41 percent higher among black New Yorkers compared to the citywide average. Eliminating these disparities requires a comprehensive approach and critical investments in public health.

Last week, the Council unanimously passed my bill to codify the Healthy NYC Citywide Population Health Agenda to increase average life expectancy in New York City to 83 years old by 2030. As part of this goal, the City aims to decrease heart and diabetes related deaths by 5 percent and screenable cancer deaths by 20 percent over the next five years. To do this, the City will increase healthcare access, expand prevention activities, and improve access to healthy foods. The plan also calls for reducing toxins in our food supply, preventing tobacco use, and reducing smoking and alcohol consumption among

New Yorkers. I look forward to a sustained partnership between this Council and the Administration to realize and build on the goals of Healthy NYC and create a happier and healthier city for all. Valentine's Day is about honoring those we love, and that includes love for our communities. Community care should be at the center of how we address glaring health disparities for women and reduce the incidence and impact of chronic disease.

I'm hopeful that today's hearing will generate thoughtful discussions and bold ideas for advancing equity in women's health.

In closing, I would like to thank Dr. Morse for attending as well my Staff, Chief-of-Staff Jonathan Boucher, Legislative Director Kevin McAleer, Legislative Fellow Andrew Davis, my Communications Director Jessica Siles (phonetic), and the Health Committee Staff, Christopher Pepe, Sara Sucher, and Mahnoor Butt for their work on this important hearing.

I will now turn it back to Chair Louis.

CO-CHAIRPERSON LOUIS: Thank you, Chair Schulman.

Now, I will turn it over to Committee Counsel to administer the oath.

COMMITTEE COUNSEL MOAZAMI: Thank you, Chairs.

Good morning, everyone. As a reminder, today is an in-person hearing with the option of virtual testimony for the public. The Committee will be accepting registrations for testimony throughout the hearing. For those wishing to testify in person, please see the Sergeant-at-Arms in the back of the hearing room to fill out a testimony card even if you registered in advance online.

For those testifying via Zoom, your name will be called and you will be prompted to unmute.

All those who wish to submit testimony, you may do so at testimony@council.nyc.gov.

We will now hear testimony from Members of the Administration.

Will you please raise your right hand?

Do you affirm to tell the truth, the whole truth, and nothing but the truth before this Committee and to respond honestly to Council Member questions?

DEPUTY COMMISSIONER DR. MORSE: Yes.

COMMITTEE COUNSEL MOAZAMI: Thank you. You may begin when ready.

DEPUTY COMMISSIONER DR. MORSE: Good morning, Chair Schulman, Chair Louis, and Members of the Committees. My name is Dr. Michelle Morse. I'm the Chief Medical Officer and Deputy Commissioner of the Center for Health Equity and Community Wellness at the Department of Health and Mental Hygiene. On behalf of our Commissioner, thank you for inviting me here today to speak about inequities in women's health in New York City.

While disparities and inequities are often used interchangeably, throughout my testimony, I will be using inequities instead of disparities to highlight the term inequities because it reflects the reality that the gap that we see in health outcomes today are the result of avoidable, unfair, unjust systemic policies and practices in our society that can be changed.

The Health Department addresses health and social inequity across New York City in partnership with community, faith-based, and healthcare organizations. The Department's work focuses on social determinants of health, such as

housing and economic status as well as environmental and commercial determinants and addresses both upstream and downstream factors to improve the health and well-being of New Yorkers.

In 2021, the New York City Board of Health's resolution declaring racism a public health crisis highlighted the long history of structural racism impacting services and care across all institutions. Structural racism is a system that excludes, marginalizes, and harms black, Indigenous, and people of color across New York City through discriminatory housing, employment, education, healthcare, criminal legal, and other systems, all of which result in avoidable and unjust health outcomes for chronic disease and many other illnesses. The New York City Health Department works to eliminate racial inequities in health outcomes and premature mortality, which is defined as death before the age of 65 years.

I understand the Committees have expressed interest in addressing the leading causes of death nationwide for women noted by the Centers for Disease Control, including heart disease, cancer, stroke, chronic lower respiratory disease, and

Alzheimer’s disease. I'll be addressing these topics as well as the impact of diabetes on women and the New York City Health Department's ongoing efforts to address these issues. Of note, in New York City specifically, the leading causes of death for women in 2021 were heart disease, cancer, COVID 19, chronic lower respiratory disease, and Alzheimer's.

It's important to note that February is both Black History Month and American Heart Month. These designations help bring awareness to the historical and systemic issues that contribute to the inequities that we're discussing today.

The City takes a comprehensive approach to addressing health inequities. The Center for Health Equity and Community Wellness itself was created to ensure a comprehensive and strategic approach to reducing racial inequities in premature death, many of which are driven by chronic diseases. As you know, heart disease continues to be a leading cause of death for women, while breast cancer is one of the leading causes of cancer death for women.

Our analysis also shows that among women, rates of hypertension, or high blood pressure, are highest among black women. A recent community health

survey found that 42 percent, 42 percent, I'm going to say the number again, of black women reported being diagnosed with high blood pressure compared to 31 percent of Latino women, 25 percent Asian Pacific Islander women, and 23 percent of white women. These inequities stem from a range of causes, including structural racism's impact on access to health, resources, wealth, quality of services, and the reality of clinical research being historically conducted with white men, as was already noted by the Chairs, and with subsequent findings often incorrectly applied to women. In addition, cerebrovascular disease, or stroke, was the fourth leading cause of death in women. In our efforts to combat heart disease, stroke, and high blood pressure, the Health Department has developed innovative programs. We launched the Take the Pressure Off Program in 2016, a hypertension initiative which takes a place-based approach to addressing inequities in high blood pressure. This program recently received a grant from the CDC to address high blood pressure in Brownsville, Brooklyn, which is a neighborhood where we have an Action Center that is highly impacted by inequities in

cardiovascular disease, which you can see on the the map to my left. Take the Pressure Off has taken a comprehensive community-based approach by linking a federally qualified health center, the BMS Family Health and Wellness Center, the Brownsville Community Culinary Center, NYCHA developments, and insurers to collaborate on improving hypertension awareness, management, and connection to care.

Take the Pressure Off offers a Hypertension 101 workshop for community groups to promote awareness and understanding of hypertension. Over the past year, we've completed 45 presentations and train the trainer events.

In addition to heart disease, we appreciate the Council's focus on cancer affecting women since it's the second leading cause of death for women. In 2021, the rate of death from cancer was about 14 percent higher among black New Yorkers compared to the citywide average. Specifically, breast cancer is one of the leading causes of death in women in New York City. In 2021, black women died from breast cancer at a rate 41 percent higher than the citywide average. In our efforts to detect and treat breast cancer, the Health Department contracts

with a mobile mammography van program to provide no-cost mammograms and patient navigation within the neighborhoods that have the highest rates of breast cancer mortality. The program aims to decrease barriers to care such as access to transportation, insurance status, and ability to pay. In the past 18 months, the program provided screenings to over 4,800 eligible women.

Notably, colon cancer, while not specific to women, is another area of focus for us. The New York City Health Department funds patient navigation services at two health service providers located in neighborhoods with the highest rates of colorectal cancer mortality. Patient navigation services enable timely screening by providing education, support, and access to resources to reduce barriers to care for those who are uninsured or underinsured. We're currently working with partners through a committee hosted by the NYC Health Department on how to improve access to colonoscopy for patients without insurance.

I now want to turn to Alzheimer's disease, also in the CDC’s top five causes of death among women. The Health Department has a new program called Building Our Largest Dementia Infrastructure,

also known as BOLD, which seeks to improve the health status and quality of life of New York City residents with Alzheimer's disease and related dementias and of their caregivers.

To achieve this goal, this initiative aims to create a diverse, multidisciplinary coalition, which will include a wide range of stakeholders who recognize how structural racism and socioeconomic inequities have increased the risk factors for ADRD and worsened outcomes for a large proportion of NYC residents. Some of these risk factors include smoking, high blood pressure, diabetes, and obesity. In the coming months, we look forward to creating a plan that is data driven, addresses social determinants of health, improves coordination, supports reduction in risk factors, and aligns with the CDC's Healthy Brain Initiative Roadmap. Through this process, we also aim to increase awareness and understanding about the importance of risk reduction, early detection, access to quality care, and supportive services for affected individuals and their families.

On chronic lower respiratory disorder, cases of asthma and related inequities are a

significant area of concern. Children are an especially vulnerable population. In 2016, the rate of asthma-related ER visits amongst children ages 5 to 17 was more than six times higher in very high poverty neighborhoods compared to low poverty neighborhoods in New York City. Because asthma can have the most harmful effects on children, the Health Department has significant resources to address and improve these inequities we see facing kids and families across the city.

Our Office of School Health provides various services for children in school including medicine administration and education. Our East Harlem Neighborhood Health Action Center offers free counseling, education, and other support services for kids with asthma, and our Tremont Neighborhood Health Action Center offers cost-free pest control services for eligible families, and our Healthy Neighborhoods program provides free home assessments for kids and adults diagnosed with persistent asthma by a healthcare provider.

While diabetes is not technically within the top five causes of death listed by CDC, it is an important condition to understand as we discuss

health inequities in our city. Diabetes prevalence has increased over the past 10 years leading to enormous harms to New Yorkers including vision loss, blindness, kidney and nerve damage, heart disease, stroke, and amputation.

Our data underscore the unfair burden that diabetes and related complication present to communities of color in New York City and communities experiencing high poverty. A critical tool to achieving reductions in diabetes rates is a long-standing successful evidence-based initiative known as the Diabetes Self-Management Program. As you may know, recent federal approval of changes to the state's Medicaid program would make the Diabetes Self-Management Program reimbursable through Medicaid, which would represent great progress if we ensure it's accessible by as many groups as possible. In addition, with the initiative from the Council, Local Law 52 passed in 2023 to develop and implement a citywide diabetes incidence and impact reduction plan will also be a critical tool in achieving reductions in diabetes rates.

The Health Department leads a number of programs which aim to address the root causes of

chronic conditions and inequitable health outcomes. Working upstream on crosscutting issues like food and nutrition security, tobacco cessation, health insurance access, and others allows us to prevent disease and impact many of the top five causes of death altogether.

On food and nutrition security, our Groceries To Go Program provides eligible New Yorkers with up to 270 dollars a month in credits to buy groceries. Health Bucks coupons can be used to purchase fresh fruits and vegetables at all New York City farmers markets. Our Shop Healthy Initiative combats predatory advertising and commercial practices that aggressively promote unhealthy food products, which are often targeted towards communities of color. This program also increases the availability of healthier foods through counter-marketing strategies and relationship building with food retailers, distributors, and community members. We're also changing the food environment to be healthier through the New York City Food Standards, which are evidence-based nutrition criteria for all foods and beverages employers serve and were developed to help lower the risk of obesity,

diabetes, and cardiovascular disease by setting guidelines for any city government facility where food is served.

We also do tobacco control initiatives because smoking is still a leading contributor to New York City deaths. Statewide, tobacco is estimated to kill 22,000 people each year. These deaths contribute to inequities in premature mortality.

Finally, we offer health insurance enrollment and access through our Office of Health Insurance Services. Individuals with health insurance get more access to preventative care and are better able to manage chronic disease.

Given this hearing's focus on inequities in women's health and the New York City Department's work to address the harms, it is critical that we address birth inequities and prioritize black women and birthing people. Even when controlling for socioeconomic and educational status, black women and birthing people are still more likely to suffer from severe morbidity and mortality. These inequities are rooted in racism and structural inequity. Contributing factors include decreased access to care, residential segregation, and stressors from

experiences of racism. Our Family Wellness Suites are integral to disrupting these systemic inequities and are part of the City's plan to prioritize maternal and infant health. Family Wellness Suites in Tremont, Harlem, and Brownsville are physical spaces for families to receive services, health education, and linkages to community resources. They provide birthing people and their families a safe, welcoming, and supportive space to participate in a range of parenting and birthing classes, breastfeeding support, connect to community resources, and receive critical supplies like car seats and pack and plays. These sites are staffed by community health workers, doulas, lactation counselors, social workers, and other public health professionals.

In FY23, the Family Wellness Suite served over 1,500 families across the three sites and distributed over 1,500 cribs and car seats and 43,000 emergency diapers.

Finally, I would like to highlight the importance of taking a place-based and race-conscious approach to chronic disease, and this is highlighted on the map to my left yet again, showing the high

rates of premature mortality in some New York City neighborhoods.

This approach serves and greatly benefits women in New York City. The Department's Public Health Corps Program is an ecosystem of community health workers and community-based organizations supported by the Health Department to center the communities with the most unfair burden of disease, be it COVID or chronic disease. Again, these are highlighted in the map.

As the public health emergency ended, we shifted this program to integrate chronic disease as a focus because of the extensive partnership, trust, and network we have built over the past three years. Community health workers now screen community members for social needs and chronic disease and make connections to health and social care.

One community health worker shared this about the impact of their work. This work allows us to build trust with community members who previously had little to no exposure. This will allow us we hope to have relationships where the community trusts us credible messengers for future health initiatives.

This is a powerful insight that speaks to the importance of the role of community health workers in building bonds to create more healthy and equitable communities.

I'd like to close my remarks, finally, I know I've been talking for a while, by highlighting the need for a comprehensive approach to addressing these key drivers of premature mortality.

In November 2023, the City launched Healthy NYC, a citywide campaign for healthier, longer lives. This effort will require public and private sectors to work together to reach our goals. I want to thank the Council and Chair Schulman for unanimously passing the legislation last week that will require the Health Department to have and update every five years a population health agenda. This will ensure that our focus and goals around creating a healthier New York City outlive any one administration. Further, the Adams' Administration recently launched Women Forward NYC, an Action Plan for Gender Equity, an investment aimed at making New York City a national leader on gender equity, including for transgender and gender-expansive New Yorkers with the ambitious goal of becoming the most

woman-forward city in the United States. Supported through City dollars, private and public partnerships, academic institutions, and federal funding, this living action plan is a framework for all of the Administration's efforts to addressing gender inequities going forward and taking immediate action to connect women to professional development and higher paying jobs, dismantle barriers to sexual, reproductive, and chronic care, reduce gender based violence against women, and provide holistic housing services, including for formerly incarcerated women and domestic and gender-based violence survivors.

The Health Department worked with our Colleagues in City Hall on the development of this plan. New Yorkers can now revisit the relaunched women.nyc, a one-stop shop website to learn more about the Action Plan and access City services to support women and families.

Thank you for inviting me to discuss this important topic. I'm happy to answer your questions.

CO-CHAIRPERSON LOUIS: Thank you. I want to talk a little bit about women's health just in general. We'll start there and move forward. How does DOHMH collaborate with the State Department of Health

to address the existing disparities and inequities in the provision of women's healthcare?

DEPUTY COMMISSIONER DR. MORSE: Thank you for that question, Chairwoman. The New York State Health Department is a real important partner in our work. The State Health Department creates a lot of the policies and supports a lot of the resourcing and federal funding that have an impact on reducing health inequities. They are also the regulatory body for healthcare institutions across New York City so we do work closely with our colleagues there. We have regular meetings and discussions around both regulatory comments that we provide, collaborative efforts with the stakeholders that the state brings together, and then with our staff counterparts in the state.

CO-CHAIRPERSON LOUIS: Thank you. What factors does DOHMH attribute to the disparities in the provision of women's healthcare, and what particular programming or initiatives does your agency conduct to address these factors?

DEPUTY COMMISSIONER DR. MORSE: Yes. Thank you for that question. Again, we're really thankful for Council's interest in focusing on women's health

and women's inequities specifically. We see many, many layers that drive the women's health inequities that New York City is facing. I think breast cancer is one of the most important areas for us to look at. Specifically, from our perspective, there are a number of reasons why we see so many inequities in both diagnosis, treatment and mortality and outcomes for women around breast cancer. It at many levels is related to everything from access to healthcare, whether that's paying fees when you're going to get that healthcare, having the time to get your mammogram every year, having the primary care doctor who can help encourage you to do that all the way up to things like not actually having reliable housing or employment, which makes doing things like an annual mammogram even more difficult so this really gets at the social determinants of care as well. It's not only the healthcare. It's also the whole entire context of a woman or someone who identifies as a woman who needs to be able to get access to those different services so we see lots of layers to the reasons why these inequities happen.

I do want to highlight one breast cancer program that I mentioned in my testimony, which is

really focused on the mobile mammograms and really bringing them to the neighborhoods where we see some of the highest rates of breast cancer mortality with the goal of really reducing as many barriers as we possibly can.

CO-CHAIRPERSON LOUIS: Thank you for that. I forgot to mention that we were joined by my Colleagues, Council Members Cabán and Gutiérrez.

Back to programmatic services, so I wanted to ask you, in addition to the mobile mammogram services you provide, what additional programs are designed for women through DOHMH and how does it also include women with disabilities?

DEPUTY COMMISSIONER DR. MORSE: Thank you for that question. The Breast Cancer Mammogram Program is one of our main programs right now for breast cancer specifically. I would say that many of the healthcare systems and institutions across the city also have specific breast cancer programs and outreach programs for preventative care, and our colleagues at sister agencies are involved in many of those programs as well. In terms of our focus on women with disabilities, I think that that's an area

that we can follow up with you on and share some more resources on what we do in that particular realm.

CO-CHAIRPERSON LOUIS: Thank you. I just wanted to quickly ask about the Mayor's new Women's Health Agenda. In January 2023, Mayor Adams announced the New York City Women's Health Agenda, now called Women Forward NYC, aimed at addressing the systemic inequity that women often experience in healthcare and in other areas in their lives. This agenda stems from the City's first ever Women's Health Summit that you all held, which convened more than 100,000 experts across various health sectors so I wanted to ask, how did DOHMH decide which health issues to focus on regarding this agenda?

DEPUTY COMMISSIONER DR. MORSE: Thank you for that question. The Health Department is involved in the Women Forward Agenda. We are one of multiple different sister agencies who are involved and City Hall led the action plan, but I can speak to the Health Department parts of it specifically. One of the ways that we contributed towards the plan was that we looked at some of our health outcomes and health data that we do surveillance on across the city and we looked at some of the biggest drivers of

preventable illness and death for women and girls, and we also looked at what are the most egregious inequities as well, and this led us to suggest a focus on four key areas to make New York City more healthy for women. Those areas are around reducing pregnancy associated mortality among black women by 10 percent, reducing breast cancer mortality by 10 percent with a focus on reductions for black women, increasing the percentage of 13 year olds with completed HPV vaccines by 40 percent, reducing the annual HIV diagnosis rates for black and Latino women by 50 percent, and reducing the percentage of public high school girls who report feeling sad or hopeless by 10 percent so those were some of the areas that our data told us should be areas of focus because of the level of inequity.

CO-CHAIRPERSON LOUIS: Thank you for that. Did you also include the data identified by the CDC as the leading causes?

DEPUTY COMMISSIONER DR. MORSE: That's a great question. We looked more at New York City specifically, but I think the overlap is 100 percent with the CDC priorities as well.

CO-CHAIRPERSON LOUIS: Research shows that BIPOC women, and particularly black women, are more likely to have poor health outcomes due to disparities in care. How is this agenda highlighting that issue and ensuring that it is focusing on the most marginalized women? You highlighted some of it, but if you could go further.

DEPUTY COMMISSIONER DR. MORSE: Yes, thank you for that question. We very much agree that we need to be focusing our resources on the communities and populations that have the most unfair outcomes, and so the way that we do that is something called Centering the Margins. It's a program design tool that is focused on anti-racism, and it's about prioritizing women of color who have the most unfair health outcomes and knowing that by targeting and focusing on that population, outcomes for everyone will actually improve. Specifically, I want to also highlight Brooklyn Borough President Antonio Reynoso's Maternal Health Task Force that we participated in, and that led to a focus on communications campaigns, giving information about nutrition, emotional wellness, legal rights, health insurance access, midwifery support, and doula

services. We also have a midwifery initiative that builds on research about existing midwifery care models across pregnancy, birth, and the postpartum period. We also run the Maternal Hospital Quality Improvement Network, which is a clinical and community initiative, that seeks to reduce inequities in preventable maternal mortality and morbidity with a focus on black women, and then, finally, we also run the Citywide Doula Initiative, which provides doula support citywide through the By My Side Birth Support Program and partnerships with other doula-led organizations so those are a few of the programs that really focus, again, on the inequitable and unfair health outcomes of black women.

CO-CHAIRPERSON LOUIS: Thank you for that. You mentioned a maternal health package that we worked on last year so I wanted to quickly ask you about two bills that we got passed last year and for some updates. In 2022, one of my bills, Intro. 482, was enacted requiring the Department of Health and Mental Hygiene to provide education on polycystic ovaries syndrome and endometriosis by posting information on its website, including but not limited to definitions of potential symptoms of polycystic

ovaries syndrome and endometriosis. I wanted to know if you could provide the Committee with an update today.

DEPUTY COMMISSIONER DR. MORSE: Yes. Thank you so much for asking that question. At this moment, I don't have information on an update on that specific bill, but we can follow up with you with more information.

CO-CHAIRPERSON LOUIS: Another bill that we got passed in 2022, Intro. 409 was enacted requiring the Department of Mental Health and Hygiene to post the annual maternal mortality and morbidity report on its website. As you were sharing earlier, this is something that's within the agenda that the Mayor put forward. Can you share a few words on that?

DEPUTY COMMISSIONER DR. MORSE: Yes, just this past September, we did post the updated data and rates around maternal mortality. That is available on our website now, and we can share that information in followup, but that was released this past September, September 2023.

CO-CHAIRPERSON LOUIS: Thank you. Besides the Borough President that you mentioned, what other

organizations and advocates are you working with in developing these programs for (INAUDIBLE)

DEPUTY COMMISSIONER DR. MORSE: Thank you for that question. One of the things that we see as critically important is to make sure that the voices of the women who've been directly impacted are central to how we design our programs. One of the ways that we've tried to do that is through developing our own Health Department Brooklyn Birth Equity Working Group. This is a part of one of the initiatives that I've been leading as Chief Medical Officer. That working group has almost 40 members that are all in Brooklyn and are focused specifically on all of the different parts and sectors of society that have a stake in reducing maternal mortality. Brooklyn is the largest borough by population and it has the largest number of maternal deaths proportionate to population as well, and so that's part of the reason we focus there, and one of the things that's being done as a part of that working group, the members of it include doulas, community-based organizations, healthcare organizations, insurers, community members, Health Department staff, as well as some of our sister agencies, including

Health and Hospitals, ACS, and others, and what we're trying to do is really use a collective impact approach because this is both a social and a healthcare issue and what we want to do is continue to reduce black maternal mortality. As described, the goal for Healthy NYC is to reduce it by 10 percent by 2030.

CO-CHAIRPERSON LOUIS: Thank you. I'm going to hand it over to Chair Schulman.

CO-CHAIRPERSON SCHULMAN: Thank you, Chair Louis.

First, I want to acknowledge that we've been joined by Council Members Ariola and Riley.

Good morning, Dr. Morse. I have a few questions, but let me start off this way. Your testimony was extraordinarily substantive so you've set the bar for your colleagues, whoever's watching in the admin.

With that, a few questions. One is, you mentioned during your testimony about the bill that was passed about the plan for diabetes. I know that that plan is due sometime in the spring. Can you give an update on where we are with that?

DEPUTY COMMISSIONER DR. MORSE: Yes, we are actively working on that plan. I can certainly share a little bit more of a progress report in followup, but our team is working with the working group that was convened to develop and influence that plan.

CO-CHAIRPERSON SCHULMAN: Okay, looking forward to that. When you talked about the mammogram van, like how often does that go out, how are the arrangements made for where it goes, and can you just give some background and details on that?

DEPUTY COMMISSIONER DR. MORSE: Absolutely. The partner that we work with who sends out the mobile vans, what they do is they work with the community-based organizations that we partner with already in the neighborhoods that have the highest rate of breast cancer mortality. They contact those community-based organizations. They describe for them and ask them what are some of the dates and locations, host locations, that would be willing to host the mobile van then what they do is actually develop materials that the community-based organizations and other partners, including elected officials and other partners in those communities can

send out to let women in the neighborhood know the date that the van will be present on that particular site and then they also do street outreach when they're doing the mobile van screening and then they host the mobile van screening for up to 20 women, a minimum of 20 women for the date that they are doing that particular screening site and then for any women whose mammograms are positive, they also have navigators who help navigate those women to the appropriate care that they need. I think that's the main process, but we can share more information in followup.

CO-CHAIRPERSON SCHULMAN: Yeah, I'd like to get information on where you do it and all of that because I want to see how I can partner and those of us in the Council can partner on that because that's something that's very important. I will tell you that when I was diagnosed with breast cancer, it was during COVID and it was during a routine screening that I pushed myself to go to, but I will tell you I met women who, because they had lost their jobs during COVID or whatever else, didn't get screened so I just want to see where we can go because I do have a part of my community that has a great need. Also, I

presume that you do it in culturally appropriate ways because I will say there are women that, certain demographics, that are afraid to go for screenings or they're not used to it or they take care of the rest of the family and they don't, you know, if something bothers them, they don't bring it forth so those are the kinds of things, the inequities, that I want to try to address as well.

DEPUTY COMMISSIONER DR. MORSE: Thank you for that.

CO-CHAIRPERSON SCHULMAN: In terms of colon cancer that you mentioned, just describe for me sort of what you guys are doing in terms of getting people screened. One, I know there's colonoscopies, but there are also measures that can be taken, there are these new tests now and things like that. Is there a way that we can help the Department of Health get some of these for women, at least for an initial assessment and then go from there? I mean for me and I'm part of, as you said, Healthy NYC and we codified that plan in legislation. I'm gonna say something now. I'm a lazy patient, all right, so, I am, but that doesn't mean I don't care about my health. We have to establish protocols and standards where

people get up in the morning, they go to work, they come home, basically, I'm being very basic here, but we need to meet people where they are and try to get them something that at least can move them forward. Not everybody has a primary care physician. That's a whole other issue that I'm not going to address today. Just tell me sort of what you guys are envisioning for that.

DEPUTY COMMISSIONER DR. MORSE: Thank you for that, Chair Schulman, and I wasn't aware of your diagnosis, but thank you for sharing that personal experience. I do want to also just mention my team just shared that we had 14 events for the breast mammography van back in December of last year so we are happy to share more information about that and follow up with you.

For colon cancer specifically, we have for over 20 years now led a coalition called the C5 Coalition. That Coalition's focus brings together healthcare organizations, cancer specialty centers, researchers, Health Department staff and really tries to look at population health level interventions to reduce mortality from colon cancer and to increase screening because timely screening is so life-saving

as you highlighted. For colon cancer, the recommendations are that anyone between age 45 and 85 are screened, and there are multiple methods for screening, as you described, including stool tests in addition to actually having a colonoscopy. Part of what we try to do when it comes to colon cancer access is we actually have a patient navigator programs as well around cancer care, and the RFP that we use to try to engage community partners and fund community partners around cancer specifically are really focused again on the neighborhoods that have the highest cancer mortality so part of the way that we also do the screenings is by educating providers. As you're probably aware, some of the providers, it can be hard as a physician to keep up with the change in guidance so we also do public health detailing where we go out to primary care practices all across the city and specifically in the neighborhoods that have some of the most unfair health outcomes and we talk with those providers and give them patient education materials in multiple languages and also give them other information about the updated screening recommendations. Now, even with all of that, as you described, it can be very difficult,

particularly if you have if you have two or three jobs, if you're a caretaker, if you're a parent, if you have unstable housing or unstable employment all of these other factors make it very difficult to do screening regularly so part of the way that we try to address that is through enrolling. We have a whole entire office dedicated to enrolling New Yorkers in health insurance, which is one of the ways to help at least decrease the cost for the screening, and there are many of our other healthcare partners who are doing other outreach and events around colon cancer and other cancer screening, but I would admit that we can always do more. I will also say, however, that that C5 Coalition over the past 20 years has really reduced some of the preventable colon cancer mortality, which I think is a very important outcome.

CO-CHAIRPERSON SCHULMAN: A question, my understanding is that in communities of color that the age is lower in terms of colon cancer. Is that correct?

DEPUTY COMMISSIONER DR. MORSE: So, it's a very important question. Some of the guidelines from the U.S. Preventative Task Force have shifted and have started to consider things like race in the

guidelines for when screening should start. I think conversations are ongoing about when that shift should happen, but yes, in some cases, race and specifically black race is a factor as well as family history and deciding if screening should start earlier than for the rest of the population that may not have those risk factors.

CO-CHAIRPERSON SCHULMAN: It seems to me that women are, that women are younger now that are getting breast cancer as well.

DEPUTY COMMISSIONER DR. MORSE: The guidance was just updated to recommend breast cancer screening starting at age 40, and we can definitely share more information about how we've updated our patient education materials and guidance based on those changes in the recommendations.

CO-CHAIRPERSON SCHULMAN: Okay, so I want to ask a couple of questions about heart disease, and I want to also acknowledge we've been joined by Council Member De La Rosa.

Heart disease continues to be the leading cause of death for women. What steps are the City and DOHMH taking to ensure that women in New York City have access to heart healthy practices and quality

medical care, particularly in terms of prevention, and then I'm going to have a followup to that, but go ahead.

DEPUTY COMMISSIONER DR. MORSE: Thank you for that. Yes, heart disease is the number one cause of death for women both nationally and here in New York City. It is an area of really intensive focus for us because hypertension and nutrition and food security both are key areas of opportunities for improvement, and those are areas that really help to address the issue of cardiovascular disease. I would say the areas that we focus on specifically or programs that we have focused on are the Take the Pressure Off Initiative. That is a hypertension control initiative that is focused in the neighborhoods that have the highest cardiovascular mortality and highest rates of hypertension. We do think it's incredibly important to note again that black women have the highest prevalence of hypertension in the whole entire city at 42 percent so that's almost one in two black women who are adults have high blood pressure in New York City so we see this as a huge issue. In the past we've done work around nutrition and food security, as I

mentioned, including access to healthy produce at lower costs, we've also done work again around the Take the Pressure Off Initiative to increase both awareness and education and partner with community-based organizations around it, and then the final thing I'll mention is our Public Health Corps program, which specifically allows for one-on-one coaching of community health workers with community members, and this part of Public Health Corps is focused specifically on residents in NYCHA in the neighborhoods within Brooklyn, Queens, Manhattan, and the Bronx that have some of the highest rates of chronic disease. What we've seen in terms of outcomes in the history of that program, again focused in NYCHA, is that there's been a significant improvement in self-rated health for the participants in that program, which is really important, and significant improvements in hypertension control for the participants in that program and, again, that is a coaching program. It's also a healthcare navigation program where thousands of members of the program actually got support in making sure they didn't have to pay for the healthcare that they needed to control their hypertension or other chronic diseases.

CO-CHAIRPERSON SCHULMAN: So, the heart age calculator tool is great for providing an estimate of your heart age based on risk factors but does not include an option for race or ethnicity. Based on the known disparities and risk factors for black and brown women, why is race not accounted for in the calculator?

DEPUTY COMMISSIONER DR. MORSE: Thank you for the question.

This is a very hotly debated topic right now in clinical care and in medicine is when should race and ethnicity be used in calculators and in algorithms to help providers to diagnose and treat illness. It's hotly debated because on the one hand, race can be a marker for risk of having worse outcomes. On the other hand, race is not a biological category at all, and so because race is a social categorization, not a biological one, it can be blurry to decide when to include race and when not to. Sometimes if you include race in a calculator, it can mean that it kind of normalizes a racial inequity in a particular disease instead of really highlighting that the only reason that that disease is more common in, say black women is actually

because of social factors, including racism, not because of black race itself, and so we have to play this very difficult balance between when to include race and when not to. In general, our guidance and our belief is that race should be included only when it's going to help us reduce racial inequities. If race is included in a calculator or an algorithm in a way that normalizes or even worsens racial inequities, then it’s not useful. If it's included in a way that is going to allow us to target resources to communities that have unfair outcomes, then it is a helpful tool to include so for the heart age calculator, I would say we have more conversation to be had about whether or not it's a useful tool in reducing racial inequities in heart disease.

CO-CHAIRPERSON SCHULMAN: The last thing I want to raise for right now is, there are, and it's just something to think about in terms of Healthy NYC, I haven't had a chance to talk to the Commissioner about this yet, but there is a new phenomenon of injectables for medications. I take one for cholesterol, for a very high cholesterol. We need to make that available to the masses and just like this Administration was very forward thinking in the

Rest in Peace Debt and putting money towards that, if there's a way that we can do this to cut down on cardiovascular disease and other things. For women, there's actually something in the pipeline because they do a lot of reading on this for high blood pressure and it's now in the second phase of the clinical trial, there's going to be an injectable where you get every six months an injection that will totally control your high blood pressure so these are things we need to really take a look at that can help a lot of people and be cost-effective so I just wanted to put that out there.

With that, Council Member Menin has some questions for you. Thank you.

COUNCIL MEMBER MENIN: Thank you so much. I really want to thank the Chairs for this very important hearing.

I have a couple questions related to cancer, and I just want to say at the outset, I think it is just so disconcerting and unconscionable nationwide that we're not seeing the cancer rates by and large falling, and it makes me think, like, if you look at back in 1972, President Nixon declared a war on cancer, and by and large, that war is, we are

in an even worse situation in so many different areas and the new research that's come out for women under 50 is really, really alarming so I have two questions related to that.

First, the mammography vans, which are so great and so important and I fully support and I'm doing one in my district. My question is, if a woman is being screened for a mammogram and you find a mass, what then happens and how is the City helping these women navigate the complex process of breast cancer?

DEPUTY COMMISSIONER DR. MORSE: Yes, thank you for that question, Council Member Menin. It's a major area of concern for us as well. One of the things that we worry a lot about is the time from diagnosis of an abnormal mammogram to a final diagnosis of what the issue might be on that mammogram and then into actual treatment if it turns out that the abnormality on the mammogram is breast cancer or some other cancer. This is one of the most important areas of intervention in cancer care in early treatment and so we agree with that concern. The current work that we do with the mobile mammography van actually does have navigators as a

part of the program, and so what those navigators do is when someone who has their mammogram on the mobile van has an abnormal mammogram, the navigator helps to reach out to them to make sure they understand the abnormality and helps them to as quickly as possible get into a followup visit to figure out if they need further diagnostic testing, whether that's a biopsy or an ultrasound or something else, and then helps them to get into treatment so that is part of the mobile mammography program. I am not saying that that happens for every mobile mammogram van but for the one that we partner with at the Health Department… (INAUDIBLE)

COUNCIL MEMBER MENIN: Just two other quick questions. The woman who has abnormal mass, what is the communication that happens? Are we following that woman? Are we in constant contact with them to make sure they are accessing treatment? And then I have one other quick question after.

DEPUTY COMMISSIONER DR. MORSE: That is exactly the role of the navigator, but we can follow up and share more data with you on what that looks like, what the calls, the text messages and what the specific followup communications are.

COUNCIL MEMBER MENIN: The last question I have is, as you know, there's incredible research on genetic mutations, not just on BRCA1 and 2, but CHEK2 and many, many others, and as someone who carries one of these genetic mutations, it has changed my life in terms of knowing that I need to have more frequent screenings, not only on breast cancer, colon cancer, all of these different areas. Some health insurance companies are now paying for this because it lowers overall the healthcare costs across the board. So what is the City of New York doing? The hearing is obviously focused on women. Are we testing women for these genetic mutations? And if so, how are we doing that? If not, why not?

DEPUTY COMMISSIONER DR. MORSE: That's a great question. I would tell you that right now there I don't think that we have specific guidance actually on that. It is something that we can follow up with you about so that we can make sure that at least what information we're sharing with patients is up to date. As far as I'm aware, I don't actually have all the information about which insurers pay for the genetic screening, and that's something that we can follow up about.

COUNCIL MEMBER MENIN: Great. Thank you very much.

CO-CHAIRPERSON SCHULMAN: Council Member Gutierrez.

COUNCIL MEMBER GUTIÉRREZ: That was fast. Thank you so much. Thank you, Chairs Louis and Chair Schulman for this hearing, and thank you, Doctor, for your testimony today.

My questions will be fast. I just wanted to quickly also uplift Dr. McNatt. I think she's been incredible, and I was able to visit the Family Wellness Suite in Brownsville and just really learn about how women are informing health decisions in our communities and how transformative that that is. My question is, I love hearing your commitment to doulas and midwives. I think it's absolutely important. Something that we're facing citywide is just this constant tussling of we appreciate you midwives, your work is paramount, but either we're not going to renew your contracts, and I know you can't speak a whole lot to it, but I just think it's really important to elevate because it's kind of contradictory to say we care about women and we care about keeping black women alive particularly, and so

we're going to create pathways to have more opportunities for midwives and doulas, and then we see citywide either a hospital is shutting, the unit is shuttering, their contracts are not being renewed, and so I would just love a sense from you all, the bigger picture with like if we are saying that this is a solution to keeping women alive, to keeping birthing people alive, then what do we need to do to ensure that we mean it? The Council, as you know, was very instrumental in passing a number of these initiatives and, again, really proud of the work that's happening in Brownsville. I loved hearing that C-sections were down, like it was all very positive and when you invest, good things happen, but what do we need to do so that we're not having these fights every year if we care about midwives and we care about doulas and we care about women, then why can't we just show up for them when it's time to pay them? That's it.

DEPUTY COMMISSIONER DR. MORSE: Thank you, Council Member Gutiérrez. I also share your admiration for Dr. Zahira McNatt and the work that the team is doing in Brooklyn and we are also really encouraged by those outcomes. A couple of things I

would say in response and completely agree with your concern, the first is that we do collaborate closely with the New York State Health Department, and that's important because they participate a lot in setting rates of reimbursement for various services. We're happy that finally Medicaid is actually reimbursing doula care starting this year at a higher rate than it had been in upstate for New York City based doulas, which is very exciting so that collaboration continues because the State Health Department is so influential in this space. We are very excited about our midwifery initiative and would love to follow up with you and set up some time to tell you more about the progress to date in the initiative. Helena Grant, who's a midwife, started working with us last year.

COUNCIL MEMBER GUTIÉRREZ: Did you know she was one of my midwives?

DEPUTY COMMISSIONER DR. MORSE: Yes.

COUNCIL MEMBER GUTIÉRREZ: It's deep (INAUDIBLE)

DEPUTY COMMISSIONER DR. MORSE: So we share your concern and, although we do not directly employ midwives who work in hospitals across the city, we do regularly have conversations with

hospitals across the city who are involved in birth equity work about ways in which they can improve health outcomes for birthing women and birthing people, and midwifery is always a part of that conversation so we'd be happy to follow up with more on our midwifery initiative.

CO-CHAIRPERSON SCHULMAN: Council Member De La Rosa.

COUNCIL MEMBER DE LA ROSA: Thank you so much. I just want to say your testimony has been great and thank you for engaging us. This is such an important topic. I wanted to ask about life expectancy, and I don't know if you've touched on this because I came a little late. I was in the Ttransportation hearing, but we've heard a lot and our Chair has really been focusing a lot about increasing life expectancy for New Yorkers, and I'm wondering if there's anything that you've looked at in terms of women, women of color in that realm.

DEPUTY COMMISSIONER DR. MORSE: Thank you so much for that question. Yes, this is a huge area of concern for us. Our Healthy NYC initiative and the goals around Healthy NYC were really all around the concerning decrease in life expectancy that happened

as a result of the pandemic, particularly in 2020, but really every year since. For the whole entire city, the life expectancy went down to 78 years in 2020. As of 2021, life expectancy on average across the city has increased to 80.7 years. We just released that 2021 data last week. We are able to look specifically at life expectancy for women. Women's life expectancy has always been a little bit higher than men's for a number of reasons. That is still the case, but overall life expectancy is still down from where it was pre-pandemic so the goal within Healthy NYC is to reach a life expectancy of 83 years by 2030 and we'd be happy to follow up with you on some numbers specifically for where women are and where women of color are. I will also say that even before the pandemic, black people, men and women together, on average had the lowest life expectancy of all New Yorkers at 74 years, and that was pre-pandemic, and to this day, we still have significant inequities in life expectancy by race and ethnicity across the city.

Can I follow up on just one other thing that came, sorry.

COUNCIL MEMBER DE LA ROSA: No, that's it. Thank you so much.

DEPUTY COMMISSIONER DR. MORSE: Thank you.

DEPUTY COMMISSIONER DR. MORSE: Thank you. I just wanted to follow up on a couple of prior questions that were raised. I wanted to add that Take the Pressure Off, our blood pressure initiative, has provided over 1,000 blood pressure monitors to sites across the city for patients with hypertension who have difficulty getting blood pressure cuffs.

I also wanted to follow up on Chair Louis, your question about Local Law 87 that was passed in 2022 regarding polycystic ovarian syndrome and endometriosis. As per the Local Law, we submitted our report to Council last year, and we'll submit a new report next month. Information about polycystic ovarian syndrome and endometriosis are also found on our website, PCOS and endometriosis NYC health. Yes, those were the two things I wanted to follow up on from other questions.

CO-CHAIRPERSON SCHULMAN: Council Member Marmorato.

COUNCIL MEMBER MARMORATO: Hi, thank you. Thank you very much, Dr. Morse, for the testimony.

I just wanted to let you know that I have a 24-year career in breast imaging, and we are in a breast imaging crisis here in the city and in the state. When your tagline is early detection is the key to survival, there is no reason why women of the city should have to wait months. It's for screening mammography appointment. Is there any initiative that you have set up where we can increase the amount of facilities or increase how these practices operate, whether they can increase their appointment time or amount of appointments? Do you have anything set up in place for that?

DEPUTY COMMISSIONER DR. MORSE: Thank you so much for that question, Council Member, and I was not aware of that expertise, but that's wonderful. We do not currently have any initiatives to increase the capacity and infrastructure around mammography in the city. However, we do see the mobile mammography van as kind of a gap filler and one way to try to bring the services to where the people are, but currently we don't have any initiatives to expand that capacity. I will also say that the more we can reduce any cost-sharing or any copays or fees that people have to potentially pay related to preventive care is

very helpful, and I would also say that part of our goal around mammography access is still reducing the rate of uninsurance for New Yorkers to zero. Nobody should be without health insurance and that would also help with access to mammography.

COUNCIL MEMBER MARMORATO: Okay. I also have an event set up in my community with the mobile vans. I'm going to try to do a couple of them throughout the year because I understand the importance of women's imaging. Now to build on Council Member Menin's question as far as the followup with these mobile vans, is there anything kind of set up in place? I've worked with clinical patients and I know how hard it is to follow up with them, and I just really wanted to know with these nurse navigators, is there any way you can set up harder guidelines or some type of database to kind of really stay in contact with these patients?

DEPUTY COMMISSIONER DR. MORSE: Thank you for that question. That's something we can definitely explore and we can follow up with you about more information on what the navigators' activities look like and how they track the information for the patients who get the mobile mammograms.

COUNCIL MEMBER MARMORATO: Okay. Thank you.

CO-CHAIRPERSON SCHULMAN: I have a question and a comment.

The question is often LGBTQ people avoid healthcare facilities due to historical discrimination and violence faced in these spaces, but when they do try to access these spaces, they're often once again receiving inadequate care because once their sexual orientation or gender identity are revealed, physicians solely focus on this aspect and relate their symptoms back to sexuality and gender. What is DOHMH doing to push back against this mentality to ensure the LGBTQ individuals are obtaining adequate care?

DEPUTY COMMISSIONER DR. MORSE: Thank you so much for the question, and this is an area of serious priority for us at the Health Department because of our health equity work. One thing that I can say is that we spent several years actually updating our internal guidance on data collection for people who are LGBTQIA, and that’s because there isn't actually a whole lot of great guidance out there on what local health departments should be

doing for data collection to make sure that we know what the sexual identity and gender identity of New Yorkers is so we have spent quite a bit of time through our data for equity work and guidance at the Health Department to make sure we're clearer and have clearer guidance in both how we collect that information and how we report it out. The data part is core to what we do. We also do service delivery work when it comes to LGBTQI populations through our sexual health clinics. Our sexual health clinics are a really amazing resource for all New Yorkers, but particularly for people who identify as LGBTQIA and specifically also for people who are concerned about their sexual health and want to have a walk-in care option so our sexual health clinics are either no cost or low cost for all New Yorkers. They're open-door policy. They have walk-in appointments or just walk-in care and address all kinds of different sexual health and reproductive health needs, and so that is another space where we really prioritize inclusiveness and really care that is competent and thoughtful and accessible for people who are LGBTQ identifying.

CO-CHAIRPERSON SCHULMAN: Didn't some of the sexual health clinics close because of budget cuts or?

DEPUTY COMMISSIONER DR. MORSE: We still have several sexual health clinics that are open, but yes, some of the services have shifted.

CO-CHAIRPERSON SCHULMAN: I want to just go back for a second to Council Member Menin's comments. The genetic testing, that's the same as biomarker. Is that correct?

DEPUTY COMMISSIONER DR. MORSE: Not always.

CO-CHAIRPERSON SCHULMAN: Not always. All right. The reason I brought it up is because there was a bill that was passed by both houses of the Legislature last year, it was on the Governor's desk, nothing happened with it to make insurance companies actually pay for biomarker testing which they don't cover now. I'm going to go back and look at that, but maybe that's something you guys can look at and look at maybe there's possibilities of doing legislation or resolutions or whatever that we can help with in terms of that and genetic testing to make sure that insurance companies actually pay for that.

DEPUTY COMMISSIONER DR. MORSE: I'm not aware of that bill, but we can look more into it.

CO-CHAIRPERSON SCHULMAN: I'll get you more information. I don't have it in front of me now. Thank you.

CO-CHAIRPERSON LOUIS: All right. Two quick questions. You mentioned earlier the Office of School Health and the focus on children so I wanted to ask how is your agency supporting mothers with children with this particular office? How do you support children who have asthma and their mothers with getting access to services?

DEPUTY COMMISSIONER DR. MORSE: That's a great question. Our Offices of School Health, we have an Asthma Case Management Program that works in certain schools across New York City, and what happens with that program is that as a child is enrolling in school, if it's noted that they have a diagnosis of asthma, the asthma case manager will contact the parent and engage with the child as well to make sure that there is an asthma management plan on file within the Office of School Health or with the school nurse at the school and will also help to coordinate care, counseling, information sharing, all

the kinds of things that would help to reduce the chances of asthma exacerbation for the child, and so that asthma case manager also certainly engages with the parent and make sure that the parent has access to the resources that they need, but that is really more focused on asthma. The school health program is focused more on asthma than other services.

CO-CHAIRPERSON LOUIS: And this is citywide?

DEPUTY COMMISSIONER DR. MORSE: We could follow up with you for the specific schools where we have that program, but yes, it is citywide.

CO-CHAIRPERSON LOUIS: So is the City also taking steps to improve air quality in areas in the city that have heightened rates of CLRD?

DEPUTY COMMISSIONER DR. MORSE: That is a great question. Our Colleagues at Environmental Health within the city, they are the part of the City government that's responsible for monitoring air quality and reporting it out and so that is a huge priority for us. In fact, I know that there is a lot of work that we're currently doing around congestion pricing and air quality related to that. We could

certainly follow up with you on some of our efforts around air quality.

CO-CHAIRPERSON LOUIS: It would be good to know how you both are partnering together to provide that.

Last question, does your agency collaborate with the Department for the Aging to ensure that older adults, particularly older women, have access to up-to-date information on Alzheimer's disease and risks?

DEPUTY COMMISSIONER DR. MORSE: Yes, I should have mentioned that earlier. Thank you for the question. We work very closely with the Department of Aging. In fact, they have several programs focused on Alzheimer's and dementia and many other areas so we do work quite closely with them, and they have been a partner to us on the initiative I mentioned called BOLD so they are partners with us on the BOLD initiative.

CO-CHAIRPERSON LOUIS: Do any other Members have any questions?

All right, I'll hand it back over to our Counsel.

COMMITTEE COUNSEL MOAZAMI: Thank you, Chair, and thank you very much, Members of the Administration.

We will now hear testimony from the public. I would like to remind everyone that I will call up individuals in panels, and all testimony will be limited to two minutes. I would like to note that written testimony, which will be reviewed in full by Committee Staff, may be submitted to the record up to 72 hours after the close of this hearing by emailing it to testimony@council.nyc.gov.

Also, if you are looking to testify in person today and are in the audience, please make sure to fill out a witness slip with the Sergeant-at-Arms in the back of the room.

For our first panel, I will call up Dorea Kyra Batte, Chris Norwood, and Christopher Leon Johnson.

You may begin when ready.

DOREA KYRA BATTE: Thank you. Good morning and thank you for convening this critical panel addressing disparities in women's health. My name is Dorea Kyra Batte, and I am an attorney at Legal Momentum, the Women's Legal Defense and Education

Fund. As the nation's first and longest serving legal advocacy organization for women, one of Legal Momentum's focus areas is to protect women and their families from being penalized for their pregnancies and pregnancy outcomes by compounding discrimination in the systems that serve them. Through our national helpline, our impact litigation, and our policy advocacy, we have seen firsthand how nonconsensual drug testing in healthcare settings negatively impact pregnant patients and their families, particularly low-income families and families of color. In performing nonconsensual drug tests on pregnant patients, a practice which is rightfully not used on all patients, healthcare providers make a treatment distinction based on sex and pregnancy, a clear violation of New York's discrimination laws. The consequences of this overtly discriminatory practice have a disproportionate impact on women. Those patients who have a positive toxicology result after nonconsensual drug testing are most often not provided any medical counseling or treatment. Rather, they are exclusively reported to Child Protective Services. Drug testing pregnant patients, not for any medical necessity but for solely punitive purposes,

amounts to an unlawful search and seizure and undermines the health and well-being of the mother and child. Numerous studies and investigative reports have found that black parents are more likely to be screened, tested, and reported for illicit drugs than their white counterparts, even though race is not associated with a positive result, and despite similar usage rates across racial groups, we have found that these practices are often more prevalent in hospitals serving lower-income black and brown communities. Because drugs testing criteria are not standardized across hospitals, healthcare providers often have discretion in determining whether or not to screen a pregnant patient, making way for implicit bias and discriminatory practices. From our experience, these practices have in fact disproportionately targeted women of color. May I continue with the recommendations.

CO-CHAIRPERSON LOUIS: All right, you have one minute.

DOREA KYRA BATTE: It is critical that patients are fully informed of the consequences of perinatal and newborn drug testing as well as the medical reasons for testing and that they be provided

the opportunity to consent to the drug test without fear that they will not receive appropriate medical care as a result. We recommend healthcare providers to establish a clear written policy that directs relevant staff to refrain from drug testing pregnant patients absent informed consent and medical necessity. In providing informed consent, staff must advise patients of all known consequences that may stem from drug testing.

In addition, we advise healthcare providers to maintain the confidentiality of any drug testing and to refrain from reporting pregnant patients to Child Protective Services based on a positive toxicology test alone, in absence, independent indicia of child abuse and maltreatment.

CO-CHAIRPERSON LOUIS: All right. Thank you.

DOREA KYRA BATTE: Thank you.

CO-CHAIRPERSON LOUIS: You may begin.

CHRIS NORWOOD: I am Chris Norwood, Executive Director of Health People. I will be focusing on two related disparities which are driving such poor health for women, especially black women, and we are in an unprecedented situation where

government at every level, and this tragically includes the New York City Council, are letting women massively suffer disability and death, which is often preventable.

These disparities are diabetes and Alzheimer's. I think Healthy NYC and the accompanying legislation are important steps, but it is also telling that Healthy NYC does not mention the fastest growing cause of death for women, which is Alzheimer's disease. Leaving from the 21st cause of death in 2000, it is now specifically the 6th leading cause of death for women.

At the same time, diabetes rose from the 8th leading cause of premature death overall to now being the fourth leading cause of premature death for women, but I caution against using premature death rates as a sole primary measure of what people are do doing. Nothing has the overall devastation of diabetes, which has struck one million New Yorkers. It fuels other diseases that deeply concern you across the board including heart disease, high blood pressure, several types of cancer, poor birth outcomes, and it is a major, major trigger of Alzheimer's. Two thirds of those with Alzheimer's are

women. We do know, however, that Alzheimer's is significantly preventable, and a major route for prevention is controlling diabetes.

People diagnosed with diabetes before age 60 have an 80 percent increase in Alzheimer's risk, but even so, helping them reduce blood sugar levels from poor control to moderate control slashes Alzheimer's risk by 30 percent and bringing blood sugar to good control slashes Alzheimer's risk by 60 percent, but this has never been incorporated into our priorities in the city at all.

Black women experience twofold the Alzheimer's rate of white women, and this means that in New York State, the same populations and the same communities that were ravaged by COVID-19 are now being ravaged by Alzheimer's.

CO-CHAIRPERSON LOUIS: If you could finish your remarks.

CHRIS NORWOOD: I will in one minute. I promise. We have begged and begged the City Council and Health Department to support community diabetes self-management education. I was happy today for the first time we did hear some beginnings of focus on that for the first time with 1 million people

affected. So we have a health department that has decreed racism a public health crisis, we have a City Council that is majority women, but we have a hideous legacy, which we must focus on, there is no other term except hideous, of neglect of the two most predominant disparities that most injure women and black women the most.

CO-CHAIRPERSON LOUIS: Thank you so much.

CHRIS NORWOOD: Thank you.

CO-CHAIRPERSON LOUIS: You may begin.

CHRISTOPHER LEON JOHNSON: What's up everybody? My name is Christopher Leon Johnson. This is my first time at a Women's Committee. It's rare for me, but when I saw that postcard over there to your right or your left on the screen, I was so disgusted of what I saw. We see over here that majority of the disparities happens more in the impoverished district and the highlighted area shows, I believe that's my District, that's my Council District, a little part of my Council District and a little part of Hudson's District. Now, the real reason this is happening is because they are allowing bad foods in these Districts, in those impoverished Districts. All the impoverished Districts have all

the bad foods. When you eat the bad foods, your high chances of having these diseases like diabetes and premature death and all the other diseases that happen to your body system will be way higher than all the other non-areas that are shaded little lighter. And we all know why is that? Because they have better food. Trader Joe's, Whole Foods, (INAUDIBLE) while all the impoverished areas have NSA and Associated and CTown and Shop and Stop and Target, which is like (INAUDIBLE) go to target is like gas food and Walmart, which is like gas food too so that's the reason it's happening because the foods are horrible. In these Districts and these impoverished Districts, you have to push for more healthier foods and more execution of the funds that the government, like the City Council and the State Assembly, State Senate, and the federal government give to these areas to implement the services to make sure that this doesn't happen. We all know what's going on with that is that majority of this money is going to these executive directors' pockets, basically in those impoverished Districts, and all these, I'm not saying all you guys here, but none of these Council Members and none of these elected

officials, all they care about is being reelected so they allow this to happen with these non-profits that so called fighting for the people, equity of health in the impoverished Districts, all they care about is lining their pockets. And one more thing is we need to stop funding these cure violence organizations because the reason I'm saying is because a number of these hospitals like Jacobi and Lincoln Hospital and King County and Downstate, they're getting a lot of money from the government for these cure violence initiatives. We have to defund that and drive more into promoting pregnancies…

CO-CHAIRPERSON LOUIS: Thank you.

CHRISTOPHER LEON JOHNSON: And maternal health and cardiovascular health in these communities so that's all I got to say. Thank you so much.

CO-CHAIRPERSON LOUIS: Thank you for your testimony.

CHRISTOPHER LEON JOHNSON: Thank you.

CHRIS NORWOOD: (INAUDIBLE) is going to the heart of the matter, and something the City Council and Health Department can do together is have New York have a waiver that really counts for health, and that is a waiver from having to distribute sugary

soda under the so-called Supplemental Nutrition Program. Ten percent of that money goes to sugary soda, and you can ask the federal government for a waiver for New York City, you could ask New York State to join in that.

CO-CHAIRPERSON LOUIS: If you could join us in that effort, we'll appreciate it.

CHRIS NORWOOD: I sure will.

CO-CHAIRPERSON LOUIS: I want to thank this panel for coming today and testifying. Thank you for your time.

CHRISTOPHER LEON JOHNSON: Thank you.

CO-CHAIRPERSON SCHULMAN: Before you go on, I want to thank you, Mr. Johnson, for testifying. I want to say a couple things. One is that that's why we have GoNYC in a lot of places and Health Bucks and I promote that and that should be promoted in a lot of different areas and so we're trying to grow that as well.

CHRISTOPHER LEON JOHNSON: Yeah, I know

CO-CHAIRPERSON SCHULMAN: I appreciate what you said (INAUDIBLE)

CHRISTOPHER LEON JOHNSON: I know you're growing it, but defund these cure violence

organizations and drop it to that. That's all I got to say.

CO-CHAIRPERSON SCHULMAN: Understood.

CHRISTOPHER LEON JOHNSON: Thank you.

CO-CHAIRPERSON SCHULMAN: Understood. Thank you. To Miss Norwood, like I said, the City Council, we're trying to move in a lot of different directions. We passed the first Comprehensive Diabetes bill last year, the Department of Health has a year, that's why I brought it up today, has a year to put together the plan and all the different elements that go with that, and that's not due until April and we're working closely with them and once that's out, we're going to make sure to include you as part of that as well so thank you very much.

CHRIS NORWOOD: You're welcome. I don't know if the actual working report has been distributed to the Council, has it?

CO-CHAIRPERSON SCHULMAN: It's due in April.

CHRIS NORWOOD: No, the working report has already been released. That's the working report, which is the basis for. I don't think that has been distributed to the Council.

CO-CHAIRPERSON SCHULMAN: We'll follow up, but it's supposed to be officially out, and I've been working with the Department of Health on looking at various aspects of it so thank you.

CHRIS NORWOOD: All right. Thank you.

CO-CHAIRPERSON LOUIS: Thank you.I'm going to hand it over to the Committee Counsel.

COMMITTEE COUNSEL MOAZAMI: Thank you. If there's no one else in the room that has signed up to testify or would like to testify, that would conclude the in-person portion of our public testimony.

We will now move to remote testimony. If you are testifying remotely, once your name is called, a member of our Staff will unmute you and you may begin once the Sergeant-at-Arms sets the clock and cues you.

The first four people on Zoom that will testify will be Elise Benusa followed by Lauren Schuster followed by Rosemary Martinez and concluding with Yesenia Mata.

Elise Benusa, you may begin once you are unmuted and the Sergeant cues you.

SERGEANT-AT-ARMS: Time starts now.

ELISA BENUSA: Good morning, everyone. I'm trying to show my video, but it won't let me so I can just go ahead.

Good morning. My name is Elise Benusa. I am the Government Relations Manager at Planned Parenthood of Greater New York. Thank you to the Committee Chairs, Council Member Louis and Schulman, for holding this important hearing addressing disparities in women's health.

PPGNY has been a leading provider of sexual and reproductive health services in New York City for more than 100 years, conducting over 132,000 patient visits per year. Since the overturning of Roe v. Wade in 2022, 26 states have imposed severe abortion restrictions. We have listened as patients described their journeys traveling across state lines to reach New York. In response to the SCOTUS decision, PPGNY has hired patient navigators to help individuals forced to travel to and living in New York City secure the care they need from a trusted provider. PPGNY applauds the New York City Council for their legislative leadership to ensure every New Yorker and folks traveling to our state for

reproductive health services receives the quality care they deserve without fear or financial burden.

This Council has shored up protections for abortion providers and patients in our city. We must continue to be the beacon of hope we aspire to be. We must continue to fund abortion access and the New York City Abortion Access Hub through the City's budget. Our recommendation to the Council is to streamline the funding-acquiring process to ensure vital organizations like New York Abortion Access Fund and the Brigid Alliance are receiving the resources they need to provide life-saving support to patients in New York and across the country.

In the months since the overturning of Roe v. Wade, our PPGNY health centers have experienced an increase in anti-abortion protests. Our Manhattan Health Center has experienced an exponential increase in protesters, which is a combination of members of the local church, pro-abortion clinic defenders, and the NYPD officers, including members of the Strategic Response Group. On the first Saturday of each month, New York City permits anti-abortion protesters to march from their church to our health center with police escorts.

Their procession concludes outside of PPGNY's Manhattan Health Center where they engage in a ritual that is intended to shame patients who are entering and leaving the health center for vital reproductive health services.

SERGEANT-AT-ARMS: Time expired.

ELISE BENUSA: Oh, can I just, I'm finished in 30 seconds.

CO-CHAIRPERSON SCHULMAN: Just wrap it up a second.

CO-CHAIRPERSON LOUIS: You have 30 seconds.

ELISE BENUSA: This attracts large crowds on either side of the issue leading to a disruption in patient care. PPGNY staff and patients and volunteers regularly face physical and verbal harassment by the anti-abortion protesters. PPGNY has been in regular communications with legislators, community partners, and the NYPD to uplift the concerns we have with patients. Our recommendation to the Council is to explore solutions to address this issue, and one pathway we recommend is for the Council to explore the current event parade issuing process that allows the church group to march to the

health center often with NYPD escorts. Resolving this issue will be a…

CO-CHAIRPERSON LOUIS: Thank you.

ELISE BENUSA: Critical step in New York being a true reproductive rights access state and will ensure that New York City is living up to its values. Thank you.

CO-CHAIRPERSON LOUIS: Thank you so much.

COMMITTEE COUNSEL MOAZAMI: Thank you. Lauren Schuster, you may begin once you are unmuted and the Sergeant cues you.

SERGEANT-AT-ARMS: Starting time.

LAUREN SCHUSTER: Hi, everybody. I'm Lauren Schuster, the Vice President of Government Affairs at Urban Resource Institute. Thank you so much for the opportunity to present testimony today. URI is the largest provider of domestic violence temporary housing for survivors and their families in the country, and we are a leading provider of temporary housing for families experiencing homelessness. Domestic violence poses a serious and growing threat to public health and safety. Though DV does not discriminate based on gender identity or sexual orientation, here in New York and across the

country women continue to be disproportionately impacted by DV. Between 2010 and 2022, women accounted for 77 percent of all victims of domestic violence homicides in New York City while accounting for only little more than half of the overall population, and the rates of domestic violence homicides and felony assaults have increased. Between the one-year period of 2021 to 2022, DV homicides increased citywide by 29 percent with a 225 percent increase in Brooklyn and a 57 percent increase in the Bronx. Just this past weekend in the Bronx, Saida Bonilla, a 40-year-old black woman, was shot and killed by her former partner, an individual who allegedly was stalking her and who Saida's family reported had been abusing her throughout their relationship. The individual also shot Saida's young nephews, age 16 and 9. A domestic violence homicide like this one has long-lasting impacts that ripple out throughout generations of families and communities. These children, their families, and the families of everyone involved, including friends, neighbors, and members of the community will be grappling with the physical, emotional, and psychological impact of this tragic situation for

years to come, and black women like Saida continue to be disproportionately impacted by domestic violence. The same is true for Hispanic women. Like many other persistent public health problems, DV impacts marginalized communities in far more significant ways. Like other growing health problems, the City has a responsibility to mobilize resources to slow the rates of domestic…

SERGEANT-AT-ARMS: Time expired.

CO-CHAIRPERSON LOUIS: If you can wrap it up, thank you.

LAUREN SCHUSTER: I will. We can stop domestic violence by investing in community-led solutions that center equity and the voices of survivors and impacted communities. We must invest in violence prevention that is designed to address family violence like youth violence prevention and healthy relationship education, trauma-informed accountability work for people who have caused harm and workforce development and economic empowerment services for survivors and their family.

I look forward to continuing to partner with the Council on this important work. Thank you again for the opportunity to testify today.

CO-CHAIRPERSON LOUIS: Thank you.

COMMITTEE COUNSEL MOAZAMI: Thank you so much. Rosemary Martinez, you will be testifying next, and I will note that you will be testifying on behalf of yourself as well as then followed by reading a testimony for Tatiana Bejar. You may begin once you are unmuted and the Sergeant cues you.

SERGEANT-AT-ARMS: Starting time.

ROSEMARY MARTINEZ: Thank you. Good morning, Women's Committee Chair Farrah Louis and Health Committee Chair Lynn Schulman, for the opportunity to speak today. My name is Rosemary Martinez. I'm the Domestic Worker Organizer with Carroll Gardens Association, one of the organizations that is part of the New York City Coalition for Domestic Work. Our coalition is a movement of domestic workers, domestic employers, parents, family caregivers, older adults, and people with disability working together to transform New York City's Care Academy into one that is equitable and sustainable for all. The coalitions leading the organization are the National Domestic Workers Alliance New York, Adhikaar, Carroll Gardens Association, La Colmena,

and Hand in Hand, the Domestic Workers Employers Network.

As other coalition members testifying today, I'm here to request your support for the domestic worker and employer empowerment initiative for Fiscal Year 2025, which will provide 700,000 in much-needed funding for outreach, education and enforcement support to over 8,000 domestic workers and employers this year and ensure domestic workers can work in healthy and safe working conditions, promoting dignity, respect, and fairness in domestic work relationships, ultimately leading to better outcomes for both workers and employers. We are working closely with our industry in the many areas of New York City and we are (INAUDIBLE) in my capacity as Domestic Worker Organizer and as a domestic worker in NYC benefits like paid time off, healthcare. Most of them not having medical coverage and retirement are still unavailable to domestic workers, who are also frequently underpaid.

Racial and gender inequity in our communities is made worse by the fact that women and people of color make up the great majority of domestic workers, despite the fact that we have

welcomed numerous significant legislative victories since 2010 such as the NYC Paid Safe and Sick Leave…

SERGEANT-AT-ARMS: Time expired.

ROSEMARY MARTINEZ: The New York Domestic Worker Bill of Rights.

We look forward to working with you to build a city where domestic work is valued and dignified. Thank you so much.

CO-CHAIRPERSON LOUIS: Thank you.

COMMITTEE COUNSEL MOAZAMI: Thank you, and just checking, did you provide the testimony for Tatiana Bejar as well, Rosemary?

ROSEMARY MARTINEZ: They have their testimony.

COMMITTEE COUNSEL MOAZAMI: Okay, perfect. Thank you so much.

The last name I have is Yesenia Mata. You can begin once you're unmuted and the Sergeant cues you.

SERGEANT-AT-ARMS: Starting time.

YESENIA MATA: Thank you, Chairwoman Louis and Council Members on the Committee for allowing La Colmena to speak today. My name is Yesenia Mata, and I am the Executive Director of La Colmena, an

immigrant and worker rights organization based on Stein Island. Through our work, we have been able to be in the forefront of supporting new arrivals, which includes women, and teaching them about the rights at work and, as well as you know, organizing on Staten Island for immigrant rights is not easy as it is known to be one of the most hostile boroughs for immigrants. But despite the threats that our center gets from those that are anti-immigrant, we stay focused on our mission, which is to empower the immigrant worker through education, culture, organizing, economic development. We are proud to say that through our work, we have been able to empower immigrant women that every day wake up to head to work to provide for their families, and whether they have been here a long time or recently, we remind them that they have rights. We remind them that they have rights such as through the Domestic Worker Bill of Rights, Paid Safe and Sick Leave, and keep reminding them that they should not be exposed to harmful chemicals at work when cleaning. This issue is important to me on a personal level as a daughter of an amazing immigrant woman who came here to work as a domestic worker to pursue the American dream.

This is why we are proud to say that we recently became members of the Domestic Worker Initiative, which includes the National Domestic Workers Alliance, Adhikaar, Carroll Gardens Association, and Hand in Hand, which together we support over 8,000 domestic workers. We hope that this year, just as we continue fighting for immigrant domestic workers for their rights, which includes their health, that we can count on your support on fighting for this initiative that supports many immigrant domestic workers and reminds them about their rights.

I thank you for your time and leadership, Chairwomen. The health of immigrant women is a fight for women's rights. Thank you.

CO-CHAIRPERSON LOUIS: Thank you.

CO-CHAIRPERSON SCHULMAN: Thank you.

COMMITTEE COUNSEL MOAZAMI: Thank you. I will note that we had registrations from Jesse McGleughlin, Alex Hayden, Sabrina Lassegue, and Black Women's Blueprint that we don't believe are online or in the room.

If there's anyone present in the room or on Zoom that hasn't had the opportunity to testify, please raise your hand now.

Seeing no one else, I would like to note that written testimony, which will be reviewed in full by Committee Staff, may be submitted to the record up to 72 hours after the close of this hearing by emailing it to testimony at testimony@council.nyc.gov.

Chairs, we have concluded public testimony for this hearing.

CO-CHAIRPERSON LOUIS: This hearing is now closed.

UNIDENTIFIED: There was a raised hand in the back of the room.

CO-CHAIRPERSON LOUIS: Sorry. Sorry?

CO-CHAIRPERSON SCHULMAN: She wants to testify.

UNIDENTIFIED: (INAUDIBLE)

CO-CHAIRPERSON LOUIS: You'll send it on email? All right. Thank you.

COMMITTEE COUNSEL MOAZAMI: Sorry about that.

CO-CHAIRPERSON LOUIS: This hearing is now closed.

C E R T I F I C A T E

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

Date February 17, 2024