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TRANSCRIPT OF THE MINUTES

Of the

COMMITTEE ON HEALTH

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HELD AT: 250 Broadway – Committee Rm.
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B E F O R E: MARK LEVINE
Chairperson

COUNCIL MEMBERS: Alicia Ampry-Samuel
Inez D. Barron
Mathieu Eugene
Keith Powers

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

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Juan Pinzon, Director of Health Services
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[sound check, pause] [gavel]

CHAIRPERSON LEVINE: Good morning, everybody. Good morning. We're going to get started. I'm Mark Levine. I'm pleased to be the new Chair of the City Council's Health Committee. I'm very excited about this hearing. I'm pleased that we're joined by Dr. Mathieu Eugene, Council Member and fellow member of the committee, and excited about our topic today. We are going to looking at the racial disparities in health outcomes in New York City and the important work of the Center for Health Excellence in addressing those inequities. This is a topic I'm excited to start off with for my inaugural hearing, and one of many pressing concerns that we'll be addressing in this committee from the opioid crisis to the lack of health insurance amongst hundreds of thousands of New Yorkers, and much else. Now, to the big picture. With the overall health and longevity of New Yorkers improving over the last decade, we have unfortunately seen unacceptably high inequities in outcomes, and persistent inequalities in health outcomes among racial and ethnic communities and socio-economic levels in our city. The level of disparity in maternal mortality

illustrates this point vividly and painfully. In New York City African-American mothers are a shocking 12 times more likely to die than white mothers from complications related to pregnancy, and tragically, the infant mortality rate in 2015 was three times higher for non-Hispanic blacks than for non-Hispanic whites, and 2.3 times higher for Puerto Ricans than for non-Hispanic whites. I'm not sure why we have the data on Puerto Ricans, and not all Latinos, but a disturbing point nonetheless. Even the current flu epidemic, the worst our city has seen in years is impact by inequality of the vaccination rates for African-American seniors is 19% lower than that of white seniors. We also know that health outcomes can vary dramatically based simply on your zip code. A child living in West Harlem in my district is eight time more likely to be hospitalized for asthma than a child in Borough Park. Adults in West Harlem are six times more likely to be hospitalized for diabetes than they are—than those in Greenwich Village and Soho, and despite a decrease in infant mortality across the city, the rate in West Harlem is still almost five times higher than the rate on the Upper East Side. DOHM's Center for Health Equity was

created to tackle this injustice head on pursuing a four pronged strategy. First, internal reforms in the department itself to help staff directly confront racism and other forms of discrimination. Second, neighborhood based strategies to deliver public health services at local offices in East Harlem and South Bronx and Central Brooklyn. So, we were pleased to tour the East Harlem Office last week. An extremely impressive operation, and third the creation of strategic partnerships with faith-based groups and other community organizations, and fourth, communication strategies, which shine a light on racial inequities in our health system. What progress have we made since the Center's founding in closing the racial inequity gaps in health outcomes in New York City? Which of the center's programs have demonstrated the greatest impact? In what ways can we extend and deepen our efforts in order to make further progress in closing the health outcomes gap? We'll explore these and other critical questions in today's hearing as we work towards our common goal of ensuring that all New Yorkers regardless of background can attain the highest level of health. Alright, I'm going to ask our committee counsel now

to swear in our administration, those testifying from the administration.

LEGAL COUNSEL: Do you affirm to tell the truth, the whole truth, and nothing but the truth in your testimony before this committee, and to respond honestly to Council Member questions?

DEPUTY COMMISSIONER MAYBANK: I do.

CHAIRPERSON LEVINE: [off mic] Okay, please begin. (sic)

DEPUTY COMMISSIONER MAYBANK: Thank you. Good morning Chair Levine and members of the Health Committee. I am Dr. Aletha Maybank, Deputy Commissioner of the Center for Health Equity at the Department of Health and Mental Hygiene, and on behalf Commissioner Mary Bassett, we thank you for the opportunity to testify. I would also like to recognize Council Member Eugene, Barron, Ampry-Samuel and Powers for your commitment to health and the wellbeing of New Yorkers, but especially a commitment to health equity. I also want to give a shout to our—our partners that are also here because the work that we do really is partnership with those who are here in the audience. It really wouldn't be possible, and for those who know, there are slides

that we have as well with our testimony. Much like other cities in our country, but at the same time unique in its own way, New York City is best understood when appreciating the distinctive characteristics of our respective neighborhoods. These characteristics that we can be proud of and promote, but also those that illustrate significant differences in the lives that are being lived across these same neighborhoods. An 11-year gap in life expectancy currently exits in our city between the Financial District in Manhattan and Brownsville in Brooklyn. Stark inequities exist across other key outcomes like infant mortality, premature mortality as well as health conditions such as asthma, diabetes and mental illness. We refer to these disparities in health as health inequities. They are a consequence of well documented social inequities that exist at the neighborhood level. They include concentrations of poverty, differences related to education and housing and incarceration. We call these drivers the social determinants of health, and they often keep our residents from living their healthiest lives. We have know for quite some time that health inequities are not a biological phenomenon, but are the result

of long tendered systems of racism that have segregated and assaulted communities of color. During the history of our institutions and government, unjust policies and practices have yielded inequitable health outcomes. So, dismantling systems and structures that perpetuate injustice requires a commitment to equity beyond equality. We must recognize that people do not start their lives with equal power and privilege, and without the advancement of equity, and what is fair and just, there can be no equality. While the national conversation regarding inequity is often characterized by class particularly in regards to wealth, in our city inequity is particularly and principally a matter of racism. The history of the New York City includes the systemic segregation of people of color into neighborhoods that were deprived of resources for decades. To this day, these neighborhoods still carry the burden of decisions made through the prism of racism. At the beginning of Commissioner Bassett's tenure, she committed the department to equity, justice and inclusion. The Principal demonstration of this was the formation of the Center for Health Equity. The Center prioritizes

the department's work on the elimination of health inequities, which are rooted in historical and contemporary injustices and discrimination, and with that commitment came an understanding of the city's historical role in executing injustice and our present responsibility to undo it. The center's first role is to reform our own institution. We're working to transform the Health Department into a racial just, multicultural organization that actively promotes and needs of communities that have been oppressed. These include communities of color and the LGBT community. Our second role is to expand the narrative around what creates health and make injustices visible through the department's data. We seek to elevate the stories of those directly affected and the efforts to confront it. The third role is to invest in neighborhoods with some of the worst health outcomes in our city. As a city agency, we also recognize our influence to inspire and encourage change. To encourage change. Sorry. Our fourth role is to engage sister agencies and other institutions and to provide guidance and support on how best they can advance equity and health in their work. To support health on the local level, we

cannot just be deciders, but far more often we need to be followers and supporters, and today I want to share with you some of the efforts or our reform with our institution and also how we are investing in our key neighborhoods. In 2016, the Center for Health Equity launched Race to Justice, our internal reform effort. We understand, as mentioned before that structural racism is the fundamental cause of health inequities in our nation, and through this initiative We are learning more about how racism operates within our institution. That is why we are engaging staff in conversations about race, power and privilege. We are also facilitating trainers to improve staff capacity to undue racism, and gender bias, and to recognize how implicit bias affects us all. Finally, we are fostering leadership for racial and gender equity and advancement. The department is working collaboratively with experts in this field, and other cities engaged in similar efforts all across this country. In order to ensure dissemination and sustainability of this effort we have organized a diverse group of core team members and staff champions from across the department, and their work is really focused on four particular areas:

Communications and organizational identity; Community engagement and partnerships; workforce equity and development; and equitable contracting and budgeting practices. A key part for implementing Race to Justice is really normalizing conversations within a department around race, gender and LGBTQ issues as well las power, privilege and equity. Since we began this effort in 2016, over 5,000 staff have received some form of training on these topics, and we anticipate that all staff will have received training over the next three years on racism and gender equity, which is in alignment with the city's race and gender equity legislation that was passed by Council in 2017, and we commend our Council as well as the Administration for moving forward on this important issue. This learning lens is already starting to change the way we do work at the Health Department. Our epidemiologists have changed how they present neighborhood level data to show more clearly the inequities that exist across the neighborhoods. The most recent community health profile showed data by community board, the local geography that parallels what most New Yorkers identify as their neighborhoods. This has made the

data more accessible and readable for residents and advocates alike. Our emergency preparedness staff have revisited how the city organizes and deploys staff in the even of a public health emergency or a natural disaster, and they are working to ensure that qualified leadership is equitably—equitably located in all neighborhoods across New York City in times of crisis. Our Early Intervention Program provides services to children under three years who are experiencing developmental delays and disabilities, and after documenting an unequal pattern, the Early Intervention staff asked questions about well why are black children not utilizing these free eligible services in the way that Latina, Asian and white children were in the city. The program is now building demand by getting out the news about these free services and educating providers in prioritized neighborhoods. While we are not the first institution to seek to become a racial just organization in the country, we have started a transformative process. It is one that we are working with our sister agencies to amplify. However, we cannot wait of our institutions to transform. We must also serve the communities who

need help now. That is why we are also focusing efforts in neighborhoods that have long experienced public and private disinvestment and have endured some of the worst health outcomes in our city. Our recently established Neighborhood Action Centers stand on the shoulder of the District Public Health Offices that were established in 2002. It also draws on the history of over a century ago of the district health centers in New York City. These were started under Mayor La Guardia and theses were meant to serve those too poor to pay for private doctors and make additional resources available to physicians working in these neighborhoods. The District Health Center movement sought to institutionalize coordination between city agencies, community partners and the neighborhood residents in order to foster collective action, and so for over a decade, the District Public Health Officers, which are located—were located in South Bronx, East Harlem and Brooklyn developed and implemented programs, conducted primary research and participated in coalitions and worked with other agencies on local projects all at the neighborhood level. And many strong initiatives started within these offices and continue today including our New

York City Teens Connection, our Teen Pregnancy Prevention Program, which started in the South Bronx and recently expanded to Central Brooklyn and Norther Central Island—Staten Island, and the programs reach and impact continues to grow. Teen pregnancy rates in New York City declined 60% from 2000 to 2015, and the racial disparity has narrowed considerably. Asthma continues to be the leading cause of hospitalization, emergency room visits and absenteeism among our children. The East Harlem Asthma Center for Excellence has served the needs of thousands of children with asthma and their families since 2008, and from the period of 2008 to 2014, the program graduates have experienced significant reductions in emergency room department visits and hospitalizations due to asthma. In Brooklyn, our office worked with the Department of Transportation to facilitate a participatory planning effort, to bring 28 miles of bike lanes to Brownsville in East New York. Neighborhoods with little infrastructure in the way of supporting active transportation. This effort was critical to promote physical activity, but also to give residents increased freedom to move about the city. Our team is now working to ensure

that that Citi Bike expands fairly by promoting accessibility and affordability to neighborhoods that could also benefit from bike share. We have also sought to elevate and address a major concern of residents and ours, which is gun violence in New York City. Our Cure Violence Program provides alternatives to violence. It's a neighborhood based health intervention focused to decrease violence and shift community norms around violence within the neighborhood. The program is now in in 18 sites in neighborhoods that have historically been impacted by gun violence and gun related homicides. This neighborhood based approach, which is also in partnership with the Mayor's Office of Criminal Justice is prat of the reason why there are only 290 murders in New York City in 2017 compared to 335 murders the previous year. It is because of all these successes and really the persistent gaps that we see om health inequities that we are committed to focusing on these neighborhoods, and figuring out even better approaches, and to this end, last year, we launched our Neighborhood Health Action Center in which we've taken underutilized apartment buildings and revitalized them by co-locating community-based

organizations, city agencies and clinical health service organizations all under one roof. We have introduced new activities and programs in these sites and centers, and they prevent convening spaces for the public to hold events, family wellness weeks that offer support to mothers, families and their—and fathers, and plans also for community kitchens and teaching kitchens. We see partners are meeting and they are organizing and they're mapping out their efforts within and outside of our walls. The Action Centers are located in respective neighborhoods of Tremont, East Harlem and Brownsville. Through co-location of services of and programs, we are better able to collectively serve community members, act as an engine of improved asset linkages, identify gaps in coverage and reduce duplication of services. A key partner in this effort has been NYC Health Plus Hospital whose health centers operate in several of our locations, and we—and having IDNYC on site in East Harlem and Tremont has brought many New Yorkers into our doors. We have also brought on a team of community health workers, and staff to support neighborhood residents to navigate what is available in the building, and to re-road them to additional

services within our neighborhoods. Governance councils are being formed to provide partners and residents an opportunity to guide our work so that we can work in partnership and have it be more meaningful. The East Harlem Action Center has numerous co-located partners, some of which are in the room today. These partners include the Association to Benefit Children, Concrete Safaris, Public Health Solutions, and Smart University. The Departments of Health—the Departments of—Department of Health Harlem Advocacy Partner Program, which is our Community Health Worker Initiative, provides over 800 residents in our NYCHA developments with one-one on coaching. And over 1,700 residents have participated in group wellness activities such as Shape Up and walking groups, and over the last year, the East Harlem Action Center received over 16,000 visits. The Brownsville Action Center has a particular focus on reducing racial disparities and the rates of infant mortality and severe maternal morbidity. The Action Center features services provided by our co-located partners like Health and Hospitals, Adult Pediatric Clinical Services and Brownsville Multi-Service Family Health Centers HIV

Care Coordination, Cardiology and Nutritional Services. Another Center partner Brooklyn Perinatal Network provides emotional support programming and peer education trainings to neighborhood women and their families. Over the last year, the Brownsville Action Center has received nearly 14,000 visits. And at our Tremont site we are providing primary care as well as teen pregnancy and opioid overdose prevention. I'm proud to announce that last week, the Action Center was officially registered with the state as an opioid overdose prevention program, delivers monthly overdose prevention trainings to community members. The Action Center is also a steering committee member of the #Not 62 Campaign. This campaign supports borough wide efforts to improve the health of Bronx residents. In addition, we are elevating the history of the neighborhood. Earlier this month we launched an exhibit called Undesign the Red Line. The interactive exhibit explores the history or structural racism and wealth inequality, how these designs compounded each other from the 1938 Redlining Map until today, and how residents, our partners and other stakeholders can come together to undesign these systems. Over the

last year, the Tremont Neighborhood Health Action Center received over 8,000 visits. The Action Centers also operate as critical conduits to amplifying other work of the Health Department in our neighborhoods. Throughout all Action Centers, we have focus and outreach to residents to help them prevent and control diabetes, and we work with the National Diabetes Prevention Program to support ten community faith-based residents and organizations who deliver year-long workshops for community members reaching over 65,000 New Yorkers each year, and in addition, the Action Center serves as a hub for community members in mental health first aid and also connecting visitors to mental health services. Over the last year, the Action Centers have collectively welcomed over 37,000 visits and provided over 500 referrals. We welcome all residents of our neighborhoods, and surrounding areas to visit us soon, and in the words of Action Center's Public Awareness Campaign, we encourage or neighbors to be heard, be powerful and to be here. This is just the start for the Center for Health Equity and the Neighborhood Health Action Centers. A lot of work is being done, and, of course there is much more work

that we need to do. Thank you for the opportunity to testify and it's an honor to lead this important mission. I'm happy to take any questions at this point. [pause]

CHAIRPERSON LEVINE: Thank you very much, Deputy Commissioner for your testimony, and for your work on these important issues. It was wonderful to see you and your team in action at the East Harlem facility. I see we have Dr. Maringo here as well. It's great to up close the kind of impact that being no the ground in the community can have, and I do want to focus on impact.

DEPUTY COMMISSIONER MAYBANK: Sure.

CHAIRPERSON LEVINE: Understanding that we are tackling problems that haven't appeared. They've been decades and generations in the making, and they have myriad causes, many of which are—are—are tied to some of the most ingrained problems we have in society--

DEPUTY COMMISSIONER MAYBANK: Right.

CHAIRPERSON LEVINE: --which you—which you have acknowledge and been quite upfront about appropriately, but having said that, it's important to track our progress on closing these gaps.

DEPUTY COMMISSIONER MAYBANK: Uh-hm.

CHAIRPERSON LEVINE: How is that you measure city's success to wards closing gaps and outcomes where we see such wide disparities based on race and geography and other socio-economic factors? What are the indicators that you're looking to?

DEPUTY COMMISSIONER MAYBANK: Thank you. So, as you—as you clearly state, you know, health inequity and solving health inequity is something that we all have a responsibility towards because we're very clear that what creates health has something to do with healthcare, but not sufficient. Something to do with the health—the public health system, but no sufficient, but also factors related to housing and education and other social determinants of health impact. What's going to happen at the neighborhood level, and for us at the Health Department of the years, you know, we—we have our surveillance methods and our community health surveys that I—I mentioned earlier with our Community Health profiles that are issued every year, and that's one way we've been able to measure trends over time, and also our vital statistics, a key role of what a health department does. What we're clear

about it, though what, you know, needs to happen moving forward is how do we think about how do we better integrate and find ways to collect and—and look at other data from other institutions that also impact the work at a neighborhood level. And the city is definitely taking a lead in that I know through the Mayor's Office of Operations and looking at social indicators and how they impact health at the neighborhood level, and then we ourselves at the Health Department also for the first time did a Social Determinant of Health Survey as well. Specifically for the neighborhoods and for us and what we're able to do at the Action Centers what we've been fortunate to have is a research and evaluation team at each one of the Action Centers, and over the years, they've been able to at minimum and maximum at times measure definitely and evaluate our programmatic work and how it's been successful and with—with the opportunities that we've had is to really pilot a lot of initiatives at this very local level, and figure out if it works, and if it works then how can replicate it across the city. And a great example is the New York City Teens Connections, which really started in the Bronx, but because it did

such a wonderful job, it was recognized nationally, and the CDC actually funded us at one point in time to really expand it to other areas across the city. And so, those are the ways that we've been using our data to really demonstrate impact, but then also grow our programs. We've also been able to look at, and I mentioned earlier our Asthma Initiative in looking at the neighborhood level, and from the time that our Harlem Center has been present from 2008 to 2014, they've been able to actually show they were at one point in time first in hospitalizations from the age of 4 to 14, and now they're actually fourth, which is not great but it's better. And they used to be first in terms of ER, but—so now they're fifth for ages 0 to, and so we're able to measure again like on the programmatic level what the impact is and what's been happening with the residents. And I mentioned earlier about Cure Violence and the reduction of violence at the community level. And then we also have our programs and our newer programs such as Harlem Health Advocacy Partners where—again, we're—we're piloting an initiative within our NYCHA houses within Harlem over five developments, and this is a community health worker program, and from the first

three years that we have had that, we've been able to demonstrate now at this point in time that we have seen increased satisfaction among our clients that we've seen improved control of diabetes and increased connection to people to follow up with care, and also improve self-reported health, which is pretty significant and important to us. And then another program I just want to highlight that we've been able to demonstrate success with, which is in Brooklyn and this was just published recently in one of the journals is our DOULA Program, which actually helps support our mothers and babies to—to live—want babies to live their first year of life, and also to support mothers' health, but we've been able to demonstrate lower rates of pre-term birth, which is a key driver to infant mortality as well as lower rates of lower birth weight itself, and then also improve patient satisfaction and their engagement with the hospital. So, those are very specific ways in which we're able to do things at a very local level, figure out what's happening and figure out how to—how we can replicate it if possible, and if we find that the results [bell] are good then how do we—we change it around in

order for it to kind of do what we would like for it to do.

CHAIRPERSON LEVINE: Right, and—and those are all incredibly impressive, and I—I know that you have a data orientation, which throughout the agency, which is what it takes to do successful public health policy.

DEPUTY COMMISSIONER MAYBANK: Uh-hm.

CHAIRPERSON LEVINE: You in your—in your remarks cited trends on asthma, on teen pregnancy rates. I'm not sure whether you cited diabetes, but that's also a well known area where there's a real disparity. I mentioned in my remarks some very painful reports recently about disparities in deaths in childbirth as well as infant mortality rates, which has been a longstanding area of disparity. So, I want to pause it now because we also been joined by our wonderful new colleague here in the Health Committee Keith Powers. Could you give us the global view on where we're at on disparities amongst different racial or socio-economic groups, and any of the areas that I mentioned or others that you might feel are relevant.

DEPUTY COMMISSIONER MAYBANK: The global view—[laughter]. I—I would—I would say and frame it kind of in our New York City context, and then you've—you've said it as—already before that many of these inequities have persisted—been persistent over time. I mean the great thing about public health and in New York City specifically we've made huge improvements of health overall, and—and for the most part with the exception of maternal mortality, health has been improved in the city, but the challenge is—and—and for all the reasons that we mentioned earlier regarding social conditions and then the structures that impact those social conditions were very clear that neighborhoods are still pretty much suffering within the context of New York City and these gaps still exist. You know that's why we're as the Center to really have some more intentional focus, and figure out what is the it that we need to do in order to really—to—to close those gaps, and I think, you know, our placement at the local level has really helped us have a better pulse on what is happening actually with people, develop the relationships in order to have community engagement and solution development. That is more meaningful. I mean

historically a lot of our institutions have been very top down and very much, you know, this is what we need to do. This is what you need to do as a community and it hasn't really worked. I think overall we'd be able to show advances, but not really at the nitty-gritty as the local level.

CHAIRPERSON LEVINE: Does the Mayor's Management Report include metrics related to inequities?

DEPUTY COMMISSIONER MAYBANK: I believe it includes measures for inequities, but I could get back to you just to be specific. I think they're working on it. Because of the racial and gender equity legislation, we have been speaking with the Mayor's office to figure out how do we—what are the metrics that need to be in place that better outline what we're doing as addmini—as—as an administration especially as we move forward to kind of figure out what are we going to do around this legislation. How are we going to implement at the city agency level.

CHAIRPERSON LEVINE: And are there any metrics on the MMR that specifically relate to your team to or to the Center for Health Equity.

DEPUTY COMMISSIONER MAYBANK: Not specifically to the Center of Health Equity. No.

CHAIRPERSON LEVINE: Right so—so the Health Department metrics are about broader public health issues, but--

DEPUTY COMMISSIONER MAYBANK: Right.

CHAIRPERSON LEVINE: --but not directly related to your center. Well, I'm going to pass it onto my colleagues for questions, and then I'll come back for more in a minute, but I—I think that we can both recognize the incredible complexity in moving the needle on—on public health outcomes in general and—and certainly specifically related to inequities, and it wouldn't be fair to—to expect that. I think—I think your—your East Harlem office has been open for less than two years. Do I have that right?

MALE SPEAKER: [off mic] Yes, in the current form.

DEPUTY COMMISSIONER MAYBANK: Right, in the current form.

CHAIRPERSON LEVINE: In the current form, yes. It goes back a century, but it--

DEPUTY COMMISSIONER MAYBANK: [interposing] Right.

CHAIRPERSON LEVINE: --it wouldn't—it wouldn't be fair to allow—expect us to—to solve public health and equities in two years on the ground in a neighborhood.

DEPUTY COMMISSIONER MAYBANK: Yes.

CHAIRPERSON LEVINE: But having said all of that, we gain a lot by tracking our progress.

DEPUTY COMMISSIONER MAYBANK: Uh-hm.

CHAIRPERSON LEVINE: And, um, the—the—the data might not be pleasant, and it might even show that we're not making progress when you look at the big picture, but better to confront that. So, that it forces us to allocate ever more resources or push the envelope in other ways, and—and later on you want to talk about the resource piece, but—but if—if we learn that we're not making sufficient progress toward closing the gap then we have to ask what more we can do, what more resources we can allocate to make the kind of progress that we need and deserve. So, I know that our colleague Dr. Eugene has questions and I'll pass it off to him.

COUNCIL MEMBER EUGENE: Thank you. Thank you very much Mr. Chair and I want to commend you for

your leadership. In addition, this very important issue, and I want to thank also Dr. Aletha.

DEPUTY COMMISSIONER MAYBANK: Uh-hm.

COUNCIL MEMBER EUGENE: Thank you very much and all the members of the panel, and I want to thank also all your colleagues, and for the wonderful job they are doing--

DEPUTY COMMISSIONER MAYBANK: Thank you.

COUNCIL MEMBER EUGENE: --for the people of New York. We all know that health it creates a very big issue, very big one affecting people from all across New York City in all five boroughs. In your testimony—testimony you say that the Neighborhood Health Action Centers are located in the respective neighborhoods of Tremont and East Harlem in Brownsville.

DEPUTY COMMISSIONER MAYBANK: Uh-hm.

COUNCIL MEMBER EUGENE: What prevents you, you know, the—the department to open in our city the Neighborhood Centers in all the areas since we know that this is an issue that affect people all over New York City, and when do you expect—one thing we anticipate that—that very important centers will

be open also, and other neighborhoods of New York City.

DEPUTY COMMISSIONER MAYBANK: A great question. So, we have focused on these three areas because that's where the data have guided us initially, and that's what we initially have funding for. We are definitely certainly open to discussing sites in other places, and—and funding for those sites as well. We do also do other work in other places in New York City even though we don't have physical Neighborhood Health Action Centers just to make sure that—that it's highlighted. Our Brooklyn space also works out of Bedford in Bedford-Stuyvesant as well as Bushwick, and then we also programming through Cure Violence as well as the National Diabetes Prevention Program, and our faith based work as well as New York City Teens Connection in areas of Queens as well as in Norther Staten Island. So, even though we don't we have a physical framework and structure of a Neighborhood Health Action Center, we do definitely have a presence in other neighborhoods across the city in recognizing that there are other areas that are also experiencing tremendous inequities.

COUNCIL MEMBER EUGENE: Thank you very for answering that. We know that in health and medicine language—our languages are very important. Let me put it communication is very important. If you are a doctor and you are seeing a patient, you cannot communicate, this is a big problem. You may be the best physician that you can be. If you don't understand your patient or the patient doesn't understand you, this is a big problem and this is dangerous.

DEPUTY COMMISSIONER MAYBANK: Uh-hm.

COUNCIL MEMBER EUGENE: I see you have been talking about all the progress, all the strategies that you know, there's—the—the department—the department is putting together is putting in place, to address the equity issue. What about languages? We know that the New York City, New York City is—I see that all the time. It's home to so many immigrant people talking different languages, and thousands of immigrant people they have their own culture, their own languages. People let's say in the caravan people and the caravan people when they come over in terms of preventive medicine, in terms of going to the doctor, they have a different

opinion. I'm telling you. You can ask many people in this room. So what the department is doing to fill this gap and to address that issue that the half equity is addressed in terms of culture, you know, issue. Language issue because thousands of immigrant people ware contributing to the fabric of New York City. They are facing barriers and among those barriers culture and languages.

DEPUTY COMMISSIONER MAYBANK: Absolutely. So, several things. It's important also to understand the role of the Center for Health Equity, and so while this is definitely the Commissioner's strongest commitment to ensuring that the—the Health Department has a focus on it, we are not the only ones responsible within the health department to make sure that equity is pursued from the agency's perspective from the Health Department, and so there are many others within our agency that are also doing work around language access, and ensuring that all languages or as many as we possibly can get are available for many of the materials that we have in terms of communication. But also what happens as a result of, you know, pursuing this lens of health and racial equity, and I use Ebola as the example of—of

when that came around a few years ago, that it was well recognized that maybe, and we were getting feedback from community residents as well and some of our internal staff that were from West African countries who experiencing Ebola among their family members and—and were having--were going through a lot of trauma, and we really took upon ourselves to make sure we were listening to exactly what was happening, and part of the feedback was what we were providing as communication materials may not have been given the message that we want to give, and so we actually took a step back, and worked with community members to make sure (1) it was in the right languages and the various languages that it needed to be in, but also languages also about the symbols and the designs and—and what are the pictures on something, and what does that communicate? And so we-we made sure that evolved that, and—and reissued that, and that was really all with the support and the help of many of our—our community members. And so, this work about equity is also pushing us as a health department across the board not as the Center for Health Equity to really challenge how we're creating the materials that we're creating, and making sure we're putting

our racial equity lens to it, and often times that means that we can't create materials in silos, and that we have to go to our neighborhood residents and our partners to get input on what is working is working in terms of our materials and what is not working.

COUNCIL MEMBER EUGENE: Yes, I do understand that you are not—your expectation of those centers that are not the only groups or organization addressing the language or cultural issues, but are you working together? Do you collaborate?

DEPUTY COMMISSIONER MAYBANK: Oh, absolutely.

COUNCIL MEMBER EUGENE: Could you--?

DEPUTY COMMISSIONER MAYBANK: Uh-hm.

COUNCIL MEMBER EUGENE: Could you explain it? Give us more detail about your collaboration with those institutions to make sure they address properly the health equity issue?

DEPUTY COMMISSIONER MAYBANK: Which institutions?

COUNCIL MEMBER EUGENE: You say that, you know, the Health Center they are not the only

institution addressing the language issue, if I understand when you said that.

DEPUTY COMMISSIONER MAYBANK: What I was saying that--

COUNCIL MEMBER EUGENE: [interposing] So, my question is that--

DEPUTY COMMISSIONER MAYBANK: Uh-hm.

COUNCIL MEMBER EUGENE: --are you communicating with those other as the groups, those other liberal group or community groups to make sure that you work together, you join forces to better address—addressing the—the health equity issue.

DEPUTY COMMISSIONER MAYBANK: Yes. So, in the example that I was explaining, I was—I'll—I talked fast so, I can talk slower again. Um--

COUNCIL MEMBER EUGENE: [interposing] I just want to, you know, like more detail about what you said there.

DEPUTY COMMISSIONER MAYBANK: Right, and so I'm—I'm going to bring it because it was really a powerful push for us, and so, our Health Department as, and I'm not talking about—I'm talking about the Center for Health -Health—Health Equity, and other folks within the Health Department.

COUNCIL MEMBER EUGENE: Uh-hm.

DEPUTY COMMISSIONER MAYBANK: Heard back from our community-based organizations, our partners within the community. We specifically reached out to many West African organizations to hear from them how—what was happening in terms of just—in terms of dealing with all that was happening with Ebola knowing that many of their families were dying back home. But also learning from our partners and our community-based organizations what are some of the best strategies that we need to take on board in order to make sure we're getting the messaging out in a proper way, and part of that messaging relates to language, that language in terms of literal words and, you know, the type of language but also the visual part of the language. And so, through the feedback that they provided us made sure that it was in the proper languages both the words, but also the visuals that were on the particular promotional materials that were—we were putting out. And so, we've worked very closely with our community partners in terms of getting feedback on how we can involve what we're doing, and how we can do it better as compared to, you know, before in the past.

COUNCIL MEMBER EUGENE: Alright, you mentioned Ebola. That's was one event.

DEPUTY COMMISSIONER MAYBANK: Uh-hm.

COUNCIL MEMBER EUGENE: That one, you know, what you mentioned that was the reaction, you know under the aftermath of Ebola, but what I'm think—talking about is if we have to be proactive, preventive and I love preventive medicine—preventive medicine. So, what I'm talking about is before the event--

DEPUTY COMMISSIONER MAYBANK: [interposing] Yes.

COUNCIL MEMBER EUGENE: --and your strategy and your strategy planning do you work together with other organizations to prevent, to be proactive. Not when something happens and you could make it with the neighborhood, we do something. Do you have in your plan, you know, how and where you communicate, you work together, you sit down together with the different organizations, and say that, you know what? Language is very important in terms of providing, you know, health to the people. What can we do together to make sure that people who are not speaking English properly can benefit from the

services that we are—we are providing? That's what I'm asking.

DEPUTY COMMISSIONER MAYBANK: [interposing] Yeah, that's clear enough. So, yes and a lot of the work in the partnerships through our Neighborhood Health Action Centers have those relationships up so that when program development is happening, we are influenced by what is actually happening within the neighborhood. We have evolved several of our materials, and have gotten feedback from Harlem specifically more recently. There's a large Mandarin community that we are learning about, and definitely engaging more with, and making sure that we are proactive in producing and developing materials, but also figuring out what we need to do better in order to address and work with the Mandarin community, which means language is a context that we have to be very aware of. We also have hosted Mental Health First Aid in Spanish to make sure that we have been responsive to the need of our communities and within our neighborhoods, and so there are many moments and—and efforts that we have, and most of our—Oh, another actually really big thing. The National Diabetes Prevention Program, nationally

actually didn't have the program in Spanish, and so we were the first ones here in New York City to do this program, this prevention program in Spanish, and made that it was offered. It actually influenced national practice as well. So, we definitely prioritize that—prioritize making sure the what we do is accessible on many levels and every level with our community partners, but a lot of this we have really learned, and been pushed by our community partners at the neighborhood level due to the relationships that we've had over the years.

COUNCIL MEMBER EUGENE: I'm looking at something, you know, from your testimony that I love. I want to read it for you.

DEPUTY COMMISSIONER MAYBANK: That's good.

COUNCIL MEMBER EUGENE: [laughs] It says that in all our potential or dissemination in system mobility of this effort we organized a diverse core team of staff, champions from across the department. It's wonderful. That's is also--

DEPUTY COMMISSIONER MAYBANK: [interposing] Yes, yes.

COUNCIL MEMBER EUGENE: --my question, you know, part of my question.

DEPUTY COMMISSIONER MAYBANK: Uh-hm.

COUNCIL MEMBER EUGENE: And you say that their work is focused on four areas: Communications, and organizing this unit's identity, community engagement and partnerships. Great. Partnership and also work force equity and development and equity constructing and budgeting practices. My question is how diverse is these teams you're talking about? How diverse is this team--

DEPUTY COMMISSIONER MAYBANK: Uh-hm.

COUNCIL MEMBER EUGENE: --the components of this team? Do we have people from across the—the communities? We cannot get everybody, but, you know, we have to when we create a team to address equity to address fairness and regardless of the department, we got to make sure that we include as many people as possible, people from all over the place, all the state, but we won't be able to include everybody, but as a many people as we can. But how—this is my last question—how diverse is the team, this team that you're talking about? How diverse is the team?

DEPUTY COMMISSIONER MAYBANK: Okay, so to clarify as far—as far as that core diverse team of champions, we're referring to folks within our agency as the Health Department. You know, often times within—when you a program within anything, we tend to as leasers within an institution pick who we feel should be a part of the team to lead the work internally, and this is part of our internal reform effort to become an anti-racist organization. So, in a way to do it different, we opened up—we opened up the application process for our entire employees, up to 7,000 employees across the agency that if they were interested in helping to lead some of this work to become an anti-racist organization, that they could—they could apply and be a part of it. And so, we have team members that are from—we have 13 divisions within the Health Department. We have team members are from all the divisions as from different levels of management or employment staff across the agency, different years of how long they've been in the agency, gender, race and ethnicity that are a part of this core team that are-that's transforming our own institutions. In addition to I think what you have mentioned, over the years again and through

the Action Centers we have developed lots of relationships, and have lots of diversity in terms of who we engage with at the neighborhood level. Each of the Action Centers are now really working towards how do we build councils that are going to—that we are going to work with, but also inform our work in more direct ways, and they have been engaging with neighborhood residents on best how to do that. So, instead of us saying that this is how it should be done, we are going to the residents in our various areas of whether we're working faith-based organizations, NYCHA developments, community-based organizations, eve the schools, and getting ideas on what should we do in order to engage people around the Action Centers to make sure that we're doing the work in the way that's most—that's best for the neighborhood, but also that's best for them as organizations and residents within the neighborhoods.

COUNCIL MEMBER EUGENE: Thank you very much, and I do appreciate all the efforts, you know, that have been done to make sure that all the team is diverse, but this is something that you opened the application for people who are interested, but I think this is our obligation as a city as government

as the leaders to do this this synergy planning in the way that—that we include people not because they're interested, but we have to have the—the plan, the synergy plan to include everybody. It is our moral obligation, and I say that. I want to put emphasis on that. We won't be able to include everybody, but as many people, as diverse people as we can. Thank you very much for all the effort that you are doing, and think you for your answers.

DEPUTY COMMISSIONER MAYBANK: Thank you. Thank you.

COUNCIL MEMBER EUGENE: Thank you.

DEPUTY COMMISSIONER MAYBANK: Thank you.

CHAIRPERSON LEVINE: Thank you, Dr. Eugene. We want to ignore—acknowledge we've been joined by our colleague on the Health Committee, Council Member Inez Barron and I believe that Council Member Powers has a question.

COUNCIL MEMBER POWERS: Yes. Thank you and congratulations to our Chair on your first hearing, right. Yes, and glad to be part of the committee, which obviously you are addressing a lot of important issues, and I thank you for the work you're doing. I walked in a late. I'm apologize for

missing parts of it, but I walked in right in right when you were talking about infant mortality and other issues. I know that in the report the—it's actually my district that does particularly well here in terms of when you talk about the equality gap and recognize that the work you're doing is to help to make sure that every district has those same opportunities. And just a quick question, and then I'll pass it back to the chair, is when you talked about infant mortality rate, you noted that in 2006 and 2015 a decline in it citywide amongst all poverty groups. I didn't see a reason or reasons maybe listed in terms of things the city had done or programs that we had invested in, or if it's other reasons that led to a decline in the mortality rate in that 10-year period?

DEPUTY COMMISSIONER MAYBANK: Sure. Well, over the ten-year period I mean I think we've had improvements in—in health in many different ways, but I would say we've done a lot of work and a lot of efforts across the city. We have Newborn Home Visiting Program that was launched maybe 15 or so years go that also focuses on visiting moms shortly after they have delivered as well as in home. So,

they visit in the hospital as well as in the home. We have other programs such as Healthy Start Brooklyn. That has had a lot of focus on Brooklyn and working with partners to help support programs such as Nurse Family Partnership, which is a well know, well established program that's not only in Brooklyn, but other places across the city, and so there's been lots of very pointed efforts in New York City to have a focus on infant mortality, and especially within the neighborhoods that we know have the highest rates.

COUNCIL MEMBER POWERS: Got it.

DEPUTY COMMISSIONER MAYBANK: And working, and we're working a lot with partners also in—in planning around what needs to happen within the neighborhoods, and to be very clear, and there are a lot of partners within this room, there are a lot of people across New York City. We have perinatal networks. We have other people who are also working with Healthy Starts within other bureaus—boroughs that have been doing work in home visiting and—and counseling and all types of work across the last—over the last couple of years, and really drilling down, and—and highlighting and calling out that infant

mortality is not just-and it's not right for black babies to be dying two to three times more likely than—than white babies. And so moving forward we're doing -really elevating this—this effort, and really working towards being more collective across city—the city government, but also with our community partners to develop plans that are more cohesive and coordinated, and focusing on areas such as safe sleep and housing and focusing on really women's health. There's been a huge shift in understanding that really drives infant mortality within the city, but also the country is how healthy a woman is before she gets pregnant and then also a recognition that structural racism has a tremendous impact on a woman and her family within the context of her neighborhood that leads ultimately to chronic stress and chronic disease, and so we fell in elevating that narrative it also creates a platform that we're more able to come together, but also for other people to see how they can be part of the solution in decreasing infant mortality in New York City.

COUNCIL MEMBER POWERS: Great. Thank you and one—one more question is I have the distinction—

actually I walked in when you were talking about the DOULA DOULA program.

DEPUTY COMMISSIONER MAYBANK: Uh-hm.

COUNCIL MEMBER POWERS: I sort of vaguely remember last year at Bellevue, which is in my district--

DEPUTY COMMISSIONER MAYBANK: Uh-hm.

COUNCIL MEMBER POWER: [interposing] -- there was a—there was a program that was cut or lost, and folks reached out to me about it. I think it was at Bellevue? Do you have any sense of what I'm talking about?

DEPUTY COMMISSIONER MAYBANK: No.

COUNCIL MEMBER POWERS: There was a—or folks that were associated with Bellevue. I can—I'll follow up with you in a—in a—

COUNCIL MEMBER [interposing] Yeah that would be great.

COUNCIL MEMBER POWERS: --in a—in an offline, but there were some concerns about cuts to a program, and I think the city was investing in, and I can—it was a while ago, but I'll-

DEPUTY COMMISSIONER MAYBANK: [interposing] Okay.

COUNCIL MEMBER POWERS: --I'll follow up with you.

DEPUTY COMMISSIONER MAYBANK: Alright, great.

COUNCIL MEMBER POWERS: Thank you.

DEPUTY COMMISSIONER MAYBANK: Great, thanks.

CHAIRPERSON LEVINE: Thank you, Council Member and I believe that Council Member Barron has a question.

COUNCIL MEMBER BARRON: Yes, thank you to the chair. Welcome. Look forward to continuing to work on this issue with you as the new chair. To the panel thank you for coming and sharing. It's—I think it's very important that we recognize as a part of the document has said that the Health Department's work is to eliminate health inequities, which are rooted in historical and contemporary injustice and discrimination including racism. I think that's important that you have that in your statement, and that until we recognize that, and the implications of how all of that has filtered into what we've been doing all these years, we're not going to make significant progress. I think I heard you also

saying that the social and economic conditions of the community contribute to chronic stress and other conditions that have a negative impact on a person's health. So, part of the reference material says that 28%--23% of black patients give birth—only 23% of black patients give birth in the safest hospitals. So, we know that a part of that is based on the lack of or the poorer health conditions that we have in our poor communities. How is your division going to address the issues of maternal mortality? How are we going to be able to reduce that? Do you see it related not just to the mothers, the mother-to-be's health condition prior to giving birth, but also to conditions that exist in those hospitals that are in our poorest communities.

DEPUTY COMMISSIONER MAYBANK: Right. So, for the--Health Department is having a lot of focus, and I'm going to ask Dr. Torian Easterling who is overseeing our Birth Equity to come up to kind of expand a little bit more, but we as the Health Department have definitely elevated this issue, and we have recently convened a Mortality Review or Material Review Committee to really on looking at cases of why women are dying in New York City as it

relates of child birth and making sure that it's definitely more intentional to find out more in-depth what is happening so solutions can be put forward and those meetings have happened more recently. So, that's something that—that has started, and we have been fortunate to receive as the Health Department for New York City, and this was just announced more funding to support how we collect data, and how we look at data to better understand what is happening at the city as a whole, but also understand what is happening in the hospitals. And then there's a lot of attention right now from the Health Department to build relationships with hospitals and meet with them and to convene with them to talk about what is the—what are their systems like, and what are the potential gaps within their systems that are not supporting women to be the healthiest that they can be or—or what's not supporting the women to get the best treatment that they could get potentially within the hospital system. So, that work is also happening, and then at the neighborhood level there has been lots of convening. [background comments] It's—it's—I feel it's good for you to meet some other people, too because they're--

COUNCIL MEMBER BARRON: I know. There's mainly Dr. Easterling. It's glad that he's here. Do you need to swear him in?

CHAIRPERSON LEVINE: And yes, we'll just have the Committee Counsel do the affirmation.

LEGAL COUNSEL: Do you affirm to tell the truth, the whole truth, and nothing but the truth in your testimony before this committee, and to respond honestly to Council Member questions?

DR. EASTERLING: I do.

CHAIRPERSON LEVINE: And since I'm new, Dr. Easterling, if you could explain your role.

DR. EASTERLING: Sure. Good morning to the committee. My name is Dr. Torian Easterling. I am the Assistant Commissioner for the Brooklyn Neighborhood Health Action Center within the Center for Health Equity, and I also work within our division with other colleagues within our department to lead our Birth Equity Initiative through New York City to really think about how we're addressing the racial inequities around infant mortality as well as maternal mortality, which is given directly to Council Member Barron's questions. And so, as the data already points out, and we have already

highlighted multiple times that the inequities still exist around maternal mortality as well as infant mortality. I think it's important to—to highlight that the division continues to work to engage our community partners around how we think strategically about the work that we do in our neighborhoods. Through our Neighborhood Health Action Centers, we are—we have established the Family Wellness Suite, which are convening spaces for women and their families to think about how we provide resources, and also to think about how we provide respite spaces for families. Again, getting to the chronic stresses that we know that exist within our neighborhoods. The other role that we are playing—playing around convening is using data to really think about how we identify (1) The root causes of these inequities, but then also to think about some of the interventions that have played out to address some of these inequities, thinking about Healthy Start Brooklyn, Newborn Home—Home Visiting, but we know that we have community partners who have been leading home visiting services who have been providing perinatal support as some of our partners who are here right now who are leading a lot of this work within our—

within high need neighborhoods. So, really thinking about how we use data. That is what we call the perinatal period of risk report, and just to get hack to—the Council Member Eugene had mentioned how we're thinking about how we inform, how we present the data. A lot of this data is well known, but we want to provide a racially justice lens to ensure that what we present comes with a—with a lens that people understand and how we can think about action steps. And so that's another example of how we're using our community input before we put out data because a lot of people know this information. But just to get to—specifically to the question around hospitals, it is important that we play a role. As you know, that the New York City Department of Health has partnerships with hospitals. We have hospitals within Central Brooklyn who are faced with this issue. Because they are safely in those hospitals, they are for—they are dealing with lack of resources and capacity to really address this issue. I think that this—it's important to acknowledge that we have provided some input into the Vital Brooklyn Plan to ensure that we elevate this issue. Because there is funding that is coming down from the Governor's Office, there is an

opportunity as we are thinking about the merger of three hospitals within Central Brooklyn and other safety net hospitals, there are best practices that can be integrated into their plan. But we need to have, you know, our recommendations taking consider— consideration into their plan, and brought to the table as well. So, I think that it's an opportunity to really address sort of the racist practice that we've seen in hospitals, but also to also think about some of the best practice that we've seen across the country as well.

COUNCIL MEMBER BARRON: Thank you. That— that's a part of the concern that I had because, as you know, Brookdale is one of the three hospitals that's a part of that. We want to make sure—I think there's a meeting that's going to be held even Thursday with the Legislators, and the state is going to be coming together--

DR. EASTERLING: Yes.

COUNCIL MEMBER BARRON: --and working further on that vital Brooklyn plan to make sure that we're aware of all of the indices that show that we have a great disparity in terms of the services that are given to black and Latinos, and how can we use

that data to make sure that we can improve what's done. So thank you so much, and I appreciate the work that you've done—that you've been doing, and the event you had last year at the Health Center. [mic squawking] It was fantastic. So, I look forward to the next one.

DR. EASTERLING: Thank you.

COUNCIL MEMBER BARRON: Thank you.

CHAIRPERSON LEVINE: I look forward to it as well. [background comments] Maybe I'll get an invite. [laughter] Okay. Thank you, thank you, Council Member Barron. Dr. Maybank, collecting data is one of the core functions of—of the department. You're collecting data from emergency rooms, and other hospital departments from medial labs from probably pharmacies and environmental monitoring from thousands and thousands of source I'm sure. To what extent do we have demographic data attached to that reporting? If for example heaven forbid we should have a pediatric death from the flu. I know your department leans about that, but do you also learn the race or other demographic data about the—the child in such a case, and—and is that a universal practice across all data collection?

DEPUTY COMMISSIONER MAYBANK: Many—much of our data collection within the Health Department has race and ethnicity or demographic s attached to it, and it's been that way at the Health Department for a long time. Whatever data sources do and how they collect the data we're not able to fully control or have—have a sense of what this is going to be, but we definitely have better data when we do have demographics attached to that data.

CHAIRPERSON LEVINE: So—so for the health conditions that we've spoken about today, mortality from heart disease, from asthma, from—from diabetes, do—do we have full coverage of demographics in—in that data collection?

DEPUTY COMMISSIONER MAYBANK: We do. I mean we have pretty good demographics. I think we always improve, and I think that is the challenge and the work of racial equity and gender equity and—and how collect data. You know, right now for the most part we have very broad categories especially as it relates to race and ethnicity, and we're very clear that there are many—I don't want to say subgroups or other groups and other ways in which people define themselves. So, as an example, Asian is a very broad

category, but many folks who identify as Asian also they come from different origins and different nationalities in which, you know, health plays out potentially in a different way. The same thing with Latinos, as you mentioned. The same with-with blacks, and so I think there's always an opportunity to get more granular in how we collect demographic data whether it's even around income and where people live, and how, you know, how micro can we really go to understand what's happening within a specific area, and among a specific population I think is an important challenge for us as folks within the Health Department. So there are always opportunities for improvement and strengthen our collection around data within New York City.

CHAIRPERSON LEVINE: And who sets those rules? Who—who determines just what demographic data is reported? You brought up a great example of Asian being such a broad term that it can sometimes obscure very important differences. When—when you receive reports from hospitals or from medical labs, are they following rules that the Health Department sets on exactly what kind of data to report?

DEPUTY COMMISSIONER MAYBANK: Right. We don't have—there are certain kinds of data that we have influence on and saying that we need to collect it within the New York City, but in terms of demographics and how agencies and institutions collect their data (1) it's going to be important to go to that institution and find out what their source is, but often times they have a source and guidelines that are provided and requirements of what they need to collect data on, and how that data is presented. We at the Health Department definitely have some level of control over how we collect our data, and what it is that we're going to present, and we can always push ourselves as the Health Department to do better, but also we can—we can work with other partners to see what they'[re doing, and I think we can work collectively to push one another to say this is what we need to collect in order to have a full spectrum of—of the picture, but no everybody has to do that, and there are not requirements always and guidelines to—to go deeper.

CHAIRPERSON LEVINE: Understood. Dr. Maybank has an MBA I think right, among his eight or nine other degrees. So, they—they-they teach you in

business school if—if you don't measure it, you can't manage it, and so I really would like to ensure that we are measuring the demographic disparities in health outcomes in this city.

DEPUTY COMMISSIONER MAYBANK: You're so right.

CHAIRPERSON LEVINE: As I mentioned before, even if what it tells us might be painful, that's the first step addressing it. So, I look forward to working with you, and your team pushing the envelope on that. First, making sure that people are reporting the full richness of-of demographic information, and secondly that we're—we're aggregating that from a citywide perspective and reporting it. Perhaps on the MMR or other outlets that—that I'd like to explore further with you. I want to just shift to the budget question for a moment. So, your—your team or the Center for Health Equity has a $14.5 million annual budget. Is that correct?

DEPUTY COMMISSIONER MAYBANK: Correct.

CHAIRPERSON LEVINE: And so, that would include, you know, on the ground program meaning your community outreach, and—and your communications work

and even the kind of internal efforts you've made to—to—to change the dynamics around confronting racial inequity that fall under the single budget of $14.5 million.

DEPUTY COMMISSIONER MAYBANK: Right.

CHAIRPERSON LEVINE: So, you've probably never heard this in a City Council hearing before, but that sounds like not a lot of money [laughter] considering --[laughter/applause] -considering that (1) the scale of your operation, but even more importantly the scale of the challenge.

DEPUTY COMMISSIONER MAYBANK: Right.

CHAIRPERSON LEVINE: And can you break out the piece of that budget which is going to your Neighborhood Action—Health Action Centers?

DEPUTY COMMISSIONER MAYBANK: I mean I referred it. So, Cassie Toner is my Assistant Commissioner of Division Management and over Finance. So, she's sitting here.

CHAIRPERSON LEVINE: Okay, and—and we--

DEPUTY COMMISSIONER MAYBANK: Strictly to—to answer these questions.

CHAIRPERSON LEVINE: Great, and sorry to do this, but if we could also have you do the affirmation.

LEGAL COUNSEL: Do you affirm to tell the truth, the whole truth, and nothing but the truth in your testimony before this committee, and to respond honestly to Council Member questions?

ASSISTANT COMMISSIONER TONER: I DO.

CHAIRPERSON LEVINE: I'm sorry again. New guy. So, you're the Assistant Commissioner for--?

ASSISTANT COMMISSIONER TONER: Division of Management, which includes the budget.

CHAIRPERSON LEVINE: Got it. Okay.

ASSISTANT COMMISSIONER TONER: So, you know, very specifically the new funding that we have for the Action Centers is $1 million per Action Center. That funds our staffing model, which is a critical part of the—the Action Center model, which I'm sure that you see in East Harlem, which is our Navigators our Promoters who go out into the community, our Referral Specialists who are doing all that exciting work on making sure people get the social services they need that, of course, are the—

address the social determinants of health. The rest is really split among our programming and has exited prior. So, NYCTC. So the Teens Connection Program oar all of our various programs have their own individual budgets and a lot of that goes towards the Action Centers, but as a whole the Action Center model was funded at $1 million per year per center.

CHAIRPERSON LEVINE: Okay. So, that must mean that we're leveraging that money partly through non-profits, which we partner with who take up residency in these centers, which brings about great synergy. In terms of the staff that you're funding with that, what would be the—the approximate head count we're getting for $1 million a year in those centers?

ASSISTANT COMMISSIONER TONER: We have about 11 staff that were added per center.

CHAIRPERSON LEVINE: Okay, got it. Well, considering they're medical professionals I'll also say there is something I'm used to hearing they included and nothing overpaid. So that, that's good to know, but, boy, that sounds like an incredible bargain, and so it leads me to ask why instead of having only $3 million a year, why don't we have 30

or 50 considering the enormous need and what sounds like a pretty reasonable cost per—per center.

[background comments]

DEPUTY COMMISSIONER MAYBANK: I mean, yeah, okay. [laughter] I can add—so I think where, you know, right now we have the three, and we are always open to discussing more and—and how—any ideas that you may have around funding other Action Centers across the city.

CHAIRPERSON LEVINE: Alright I know that there's a—there's a capital need, and we were lucky I think in all three of these locations to have a legacy of a—of a facility that was created in some cases 100 years ago. Are there more—if that's the right term—legacy facilities out there that might need a renovation, but at least they're---they're in our in our inventory that we could bring back to life?

DEPUTY COMMISSIONER MAYBANK: Yes.

CHAIRPERSON LEVINE: There are? How many more are there?

DEPUTY COMMISSIONER MAYBANK: I can get back to you with that number--

CHAIRPERSON LEVINE: Okay.

DEPUTY COMMISSIONER MAYBANK: --so we can talk more about that.

CHAIRPERSON LEVINE: Okay, okay. Is—is—is that a politically sensitive question, or it's just that you have the number off hand? It's fine if you want to get back to me, but--

DEPUTY COMMISSIONER MAYBANK: There's a mix. I don't have the number offhand. I mean I have an estimate, but I think there's, you know, we can get back to you.

CHAIRPERSON LEVINE: Do you know, at the height of—of what at the time was very innovative with this district office—District Health Office program, do you know how many facilities we had at—at a peak?

DEPUTY COMMISSIONER MAYBANK: Yes. There are about 30, a little—a little over 30 facilities across the city, and so you—you were at the flagship program that really was—it was a pilot initial—initially, and the Red Cross approached the Health Department. They showed success over actually three years initially, and then the city funded the building of the building at the Harlem site, and it was really from that success, and demonstration over

ten years of a decrease in infant mortality and premature mortality that the city felt that they needed to invest in other health—district health centers across the city specifically in areas that they knew had the worst health outcomes, and at that time many immigrants and blacks and—and Latinos lived in those neighborhoods.

CHAIRPERSON LEVINE: Well, there's no doubt that these are priority areas and—and—and I, you know, I applaud you for putting your resources where the need is greatest, but just to understand. So, 30—so at 30 facilities, are—are they currently abandoned? What—what is the use currently for these facilities?

DEPUTY COMMISSIONER MAYBANK: So, over time, you know, and I would have to get back to you as far as the number of facilities exactly and—and speak to our admin, people to have the number more exact in my mind, but in terms of overtime, what we've experienced as the Health Department is that there was an underutilization of the buildings. You know, we have gone through periods of where the Health Department has been very centralized and then decentralized in the early 1900s, and then became

very centralized again and, you know, we did offer a lot sort of health clinical services, but as you know, we're not really in that business so much any more. So, those buildings became even more underutilize and that when Dr. Bassett came back on board in 2002, there was recognition that we can't be so centralized any longer as a Health Department because we're—one because these disparities exist within these neighborhoods, and we don't have a sense of what's really happening because we don't have teams that are really present there to be within the spaces to—to talk with people and to work with people in a very intentional way. And she—her attempt with what we call the District Public Health Offices at that time were to-to at least admittedly with what she did have, decentralize as best as she can, and then when she came back on board again having a commitment to a neighborhood approach and figuring out what it is that we can do. So, while it definitely, you know, you know, could be more, I will say it is more than what it was three years ago, and our commitment as the Health Department to what is happening, and being present at the local level where we know disparities exist in the city.

CHAIRPERSON LEVINE: Right. Look the health—the public health landscape is always changing, and today if you look at the top, as you well know, the top preventable diseases they are things are heart disease and diabetes and-and gun violence unfortunately is high on the list. And, to combat them, I think there's a stronger argument than ever for being on the ground in communities. We need to impact things like diet and exercise, and to be present in neighborhoods. There's just no substitute for it.

DEPUTY COMMISSIONER MAYBANK: Absolutely.

CHAIRPERSON LEVINE: And so, it—it may be that there was an argument for centralization in a different era. We were combatting a different list of top diseases, but boy it sure feels like what we're struggling with today that you couldn't do all that from your wonderful building in Long Island City, and I'm sure you agree. It's part of the rationale for your—for you office, but, you know, I would certainly like to explore with you--I'm getting lots of nods from Council Member Powers—the—the idea of—of dramatically increasing our on-the-ground presence and we've—we've had a proof of concept now

in three neighborhoods, and kudos to Commissioner—Commissioner Bassett--

DEPUTY COMMISSIONER MAYBANK: [interposing] Yes.

CHAIRPERSON LEVINE: --for—for re-envisioning what a local office can be in—in the 21st Century. But now we've got a couple of years of experience. There seems to be enormous demand as evidenced by the 16,000 visits a year, or 15,000 visits a year. So, we've answered that question. You know, the people—the communities want this obviously and are willing to come in. So, let's-let's—let's work together on finding a way to—to extend this success in other neighborhoods.

DEPUTY COMMISSIONER MAYBANK: Absolutely and we're working to make sure, you know, as you mentioned earlier that we're definitely evaluating the model and—and what it is because it is unique and having co-located partners and the clinical entities of the community-based organizations. But, I also want to say, if I'm allowed, that it's important to understand that, you know, we need to be present in the neighborhood. It provides another opportunity to work with other city agencies that are also in the

neighborhood because if we understand that all of these other things impact health and create health in terms of whether it's housing, or education, mass incarceration, that it's not only the sole responsibility of the health and the health field to create and resolve and decrease the gap in health inequities. And, I think it provides a wonderful opportunity for us at the Health Department to work with our city agencies to actually help them put a health lens and understand the health impacts of their work, and we have had—we have led some of that work under the leadership of doctor—doctor—Major Doctor Javier—Javier Lopez who is one of our assistant commissioners who had done great work. It's not—it's not health in all policies per se, but it's health in all policies, right, in which his team of some city planners have worked to build capacity of other—other city agencies to just understand that creates health overall and—and all of that—that often times people really aren't clear about. They think health is just about the healthcare system, and the hospital. But also to understand the equity impacts potentially of their—their work. And, what it has led to over the last year is these plans that have

come out through the city, our Bushwick Plan, our Brownsville Plan. You can see there are explicit callouts for health now, and health inequity within their—in these plans. Now, how that all materialized to action, it's not completely clear, but at least it's a start that we're able to, you know, get the city agencies to start seeing this particular lens. But that's an area I think that if we're pursuing health equity, and we're really focused at the neighborhood level of—of achieving, closing these gaps, that we also have to figure out how we're working with other city agencies to implement a health lens.

CHAIRPERSON LEVINE: On—on the funding front, almost every agency—I think actually every agency in New York City gets some federal money, but like galvanizing for the Health Department it's—it's quite a large portion of your total budget. One program that I believe is funded federally through the CDC is the Teen Connection Program.

DEPUTY COMMISSIONER MAYBANK: Uh-hm.

CHAIRPERSON LEVINE: Can you comment on the risks that we face from a hostile White House and Congress who I'm imagining are undervaluing the kind

of important public health work that you're doing, and whether we've actually have already taken hits on federal funding through the Teen Connection program or others?

DEPUTY COMMISSIONER MAYBANK: Yes. So, we've learned that the program will be cut nationally, and it—funding will end this coming June. So, you know, it impacts a large part of—of the work that we do. We reach currently 15,000 young people across New York City through linking community health centers with high schools, making sure that teens have access to and are utilizing their local health care centers, but also ensuring that these health centers are also teen friendly and responsive to young people. And we've been working with DOE to implement curriculums that help promote racial justice, but—not racial well racial justice and reproductive justice in ensuring that young people understand and know their sexual and reproductive rights, and—and will access information in the way that they need to, and then we've been working with young people to also be leaders of this campaign, the Develop Communications Campaigns across the city. So this cut will have a tremendous impact on our ability

to engage with teens across New York--New York City, and as I mentioned before, this has been one of our successful programs in which we started, you know, in one area and expanded in others because it demonstrated tremendous success, and we have seen, you know, decreases definitely within the Bronx teen pregnancy rates, but also across the board in New York City.

CHAIRPERSON LEVINE: And-and so what is the budget of that program, and is it entirely federally funded, and is that now all been cancelled?

DEPUTY COMMISSIONER MAYBANK: So, I'm going to call up so that you get to meet another Assistant Commissioner--

CHAIRPERSON LEVINE: Okay, that's great.

DEPUTY COMMISSIONER MAYBANK: --because I—you're going to get to meet almost all of them hopefully.

CHAIRPERSON LEVINE: Right.

DEPUTY COMMISSIONER MAYBANK: Dr. Jane Bedell, and she's over our Bronx Office, who has been really the leader and pioneer in pushing this program and creating the model.

DR. JANE BEDELL: Good morning.

LEGAL COUNSEL: Do you affirm to tell the truth, the whole truth, and nothing but the truth in your testimony before this committee, and to respond honestly to Council Member questions?

DR. JANE BEDELL: I do.

CHAIRPERSON LEVINE: And so, Dr. Bedell, you're running the South Bronx Health Action Center. Is that your role?

DR. JANE BEDELL: That is my role--

CHAIRPERSON LEVINE: Okay, got it.

DR. JANE BEDELL: --and in that role now that New York City Teens Connection is—has expanded, I'm also, you know, what we call the Lead Assistant Commissioner for New York City Teens Connish—Connection as well.

CHAIRPERSON LEVINE: Okay and so these budget questions. What is the budge of the program?

DR. JANE BEDELL: Yeah. So, the budget is approximately $1.2 million. We were first funding from the CBC at a slightly lesser annual budget, and then the—this work at the federal level moved to another part of Health and Human Services, the Office of Adolescent Health, and we got even more funding when we applied for a grant there. We're in the

middle of second year, and we've been, you know, like our colleagues across the country rudely told that our five-year kind of guaranteed funding is not really guaranteed, and it's going to end in Junes. So, it's devastating to—to many--

CHAIRPERSON LEVINE: [interposing] So the program--

DR. JANE BEDELL: --many municipalities.

CHAIRPERSON LEVINE: --as of now is set to close June 30th?

DR. JANE BEDELL: Yes.

CHAIRPERSON LEVINE: Have—have we not looked at a plan to replace the funding year with city money or another source?

DEPUTY COMMISSIONER MAYBANK: We are pursuing looking at a plan.

DR. JANE BEDELL: Yes, we—we are in negotiations, and talking about how we might be able to fund some of it. I--I—I don't—it would be hard to -to get CTL money that would be as richly endowed as the federal grants are, and also to say that the federal grants have with them this ability to do some connecting with other cities and municipalities that look like us, and to learn from them. So, even with—

if we are able to get funding to continue the program, there are aspects of the federal funding that are very important to, you know, nationally, and we at least during this presidential administration are unlikely to be able to be learning from our colleagues across the country.

CHAIRPERSON LEVINE: Pleas keep us posted on this. It would be tragic if the program was discontinued.

DR. JANE BEDELL: Yes.

CHAIRPERSON LEVINE: I think it's important to prepare alternate financing if that does come about.

DR. JANE BEDELL: Great. Yes.

CHAIRPERSON LEVINE: Please keep us posted and—and let us help if we can.

DR. JANE BEDELL: Okay. We'll do that.

CHAIRPERSON LEVINE: We haven't talked much about the specific healthcare challenges faced by LGBTQ New Yorkers. I know that is part of your mandate, and I think you have a task force that is specifically addressing that, and I wonder if you could say a word or two about the—how you characterize the challenges for that important

segment of New Yorkers, and—and what your role in addressing it is.

DEPUTY COMMISSIONER MAYBANK: Sure, so I am going to call my other director and Assistant Commissioner Javier Lopez up, but in the meantime before he—he comes up, what we've been able to—to work at and this was really under the leadership of Johnson, who was committee chair before really highlighting and recognizing that we need to have very specific efforts with the LGBT community and that we need to have teams and staffing that are working in that way. And so, you know, he designated and the City Council designated and—and asked that there be liaisons at the agencies, and we took that on, but we also made sure that we also provided additional funding and actually have more—more of a team than one person. And so what the responsibility of this team is, is (1) working internal to the agency, and making sure that we're coordinating efforts, and so we have a lot of work actually coming out of the Health Department through our Bureau of HIV that has issued a Healthcare Bill of Rights through some of our mental health first aid work. Also working very closely with the Unity Project with

the—with the Lady's--the First Lady's Office. And then making sure—we just launched Out for Safe Spaces in which we're working with community-based organizations.

ASSISTANT COMMISSIONER LOPEZ: I bless the prompt. So, everybody can get excited and you—you-the City Council could become an Out for Safe Spaces space.

CHAIRPERSON LEVINE: Alright

DEPUTY COMMISSIONER MAYBANK: So, working with community-based organizations and clinical and hopefully clinical entities to make sure that they are building their capacity so that they are responsive and relevant for our LGBTQ and TGNC communities and especially our communities of color. We have been working with faith-based organizations as well as our Cure Violence partners to elevate and build their capacity to talk about the stigma as it relates to LGBTQ and TGNC Communities and really address masculine toxicity as well. And so there are different ways in which, you know, we're working to coordinate within our agency. We're working and we're liaisons with the Mayor's Office, with the First Lady's Office, with the Commissioner of Gender

Equity. We're also working internally to train our own staff. We have now a Gender Equity Module that staff have to actually complete. Most I think many staff across the city have to, and our teens help developed this particular training module, and then we're also working as I mentioned with—with the United Project. Javier, do you want to--?

ASSISTANT COMMISSIONER LOPEZ: [off mic] I think you covered everything in your remarks. I can go deeper if you think I should. (sic)

DEPUTY COMMISSIONER MAYBANK: Okay. So, I—I guess I handled this.

CHAIRPERSON LEVINE: I think—I think you did—

DEPUTY COMMISSIONER MAYBANK: [interposing] Okay.

CHAIRPERSON LEVINE: --a swell job there.

DEPUTY COMMISSIONER MAYBANK: Thank you.

CHAIRPERSON LEVINE: Very good.

DEPUTY COMMISSIONER MAYBANK: Thank you.

CHAIRPERSON LEVINE: Alright—alright, well thank you so much, Commissioner Maybank and to the great team that you brought forward today. We

really look forward to working with you on these important issues.

DEPUTY COMMISSIONER MAYBANK: Thank you.

CHAIRPERSON LEVINE: Okay, and we're going to call up our next panel, which is Juan Pinzon from the Community Service Society, Mary Luke, and Sheila Katzman both are from—thank you--CEDAW New York. [background comments, pause]

CHAIRPERSON LEVINE: Okay, welcome to you all. We're going to have a three-minute clock on—on you all, but—but there will be time for questions as well, and would you like to kick us off?

SHEILA KATZMAN: Okay. Thank you very much. My name is Sheila Katzman. I am the President for the International Association for Women in Radio and Television, USA and the Chair of the Steering Committee for the New York City 4 CEDAW Act. We're a voluntary community based coalition advocating for women's rights—the women's bill of rights in New York City based upon international standards embodied in CEDAW, with is the Convention and the Elimination of all forms of Discrimination Against Women. First, we wish to express gratitude to you Council Member Mark Levine and for the Council in general for inviting us

back here again. We also want to focus a bit here on mental health, and want to emphasize our appreciation to the First Land Chirlane McCray for the initiative on Mental Health. Allow me to highlight three specific articles of the 17 Articles of CEDAW that have particular resonance to women's health and mental health, which always seems separate. Article 12: Health Care and Family Planning. Countries must guarantee equal access to health care and ensure women and girls are not discriminated against in health care and have access to services. Article 13: Economic and Social Life and then and last Article 16: Marriage and Family Life because even listening around I didn't hear any of these things coming out. Could the results of discrimination over time lead to mental health problems preventing women from reaching their potential and tying girls into early marriage, which we know do sometime here could result in depression and/or other mental health problems. Having said all that, with a gender assessment New York City CEDAW Act would require the DOM—DOHMH to play—to pay close attention to trends and make sure problems and proper—are properly identified. The—too often the media is inundated with news on mental

health. However, we are concerned that these reports usually refer to men and to men who are privileged like the Las Vegas shooting—shooter or the most recent shooter in Florida. Mental health becomes a major topic when we speak of homelessness and mental health the gender is male. We are concerned that women will be overlooked, or worse excuse their needs without asking them. Race and gender clarifies who can be identified as having mental health problems or being merely a valiant criminal depending on race and gender. Too often women are this big discriminated majority. Historically, mental health has been used to take away women's voices with egregious practices of drugs and even institutionalization. Thankfully, we are no longer at the place—that place, but we wish to ensure that this will never happen again. Our major ask is that each city agency and department assess their work through a gender lens. The city is a major employer. The city is a major implemental program. The city is a major founder of projects. In each of these areas, we want to ensure that gender discrimination is a thing of the past. A key component to any gender assessment is access to desegregated data. [bell] There are many areas that

may be inadvertently overlooked, and the gender assessment will ensure that nothing is missed. A gender assessment will help the city and the public to identify these problems and allow the city to take action. Gender assessment needs assess to—to access the data that is disaggregated by gender and is accessible to the public. Lastly, we recommend the Department of Health in its collection of data broken up by gender and wish for its continuance for the public access to raw data. We would like to ensure that this data collection is incorporated in law and not policy so that future administrations may not easily change this forward looking strategy. We know that other forms of discrimination aggravate problems with gender. So, we recognize that intersectionality also requires disaggregation of data by race and other traits that have historically discriminated against women. We would also ask, too, that when we get these invitations, which we got pretty late, that we get some backup background information, which we go when we arrived here. Thank you.

CHAIRPERSON LEVINE: Okay. Well, thank you, Ms. Katzman for your testimony and for bringing this very, very important issue to light. If you

haven't already, let's make sure you also connect to our Committee on Women's Affairs. Maybe we have joint hearing at some point. They have a wonderful chair in Helen Rosenthal. Perhaps we can team up to look at gender concerns or the concerns of women as they related health more broadly, and so we'd love to have you as part of that conversation.

SHEILA KATZMAN: Thank you.

CHAIRPERSON LEVINE: Okay, is it Ms. Luke? Is that right.

MARY LUKE: Yes.

CHAIRPERSON LEVINE: Okay, please.

MARY LUKE: Thank you. Thank you so much, Commissioner and congratulations, and--

CHAIRPERSON LEVINE: I'm just a lowly City Council Member--

MARY LUKE: Oh, well. [laughter]

CHAIRPERSON LEVINE: --not a commissioner, but--

MARY LUKE: That's true. [laughter] Anyhow I'm—I am the President of the U.S. National Committee the Metro New York Chapter and also on the Steering Committee of this New York City 4 CEDAW Initiative, and I think what we bring here is the

global perspective and the ability to connect the global issues with the local issues, which I think you--you asked earlier about the implications of New York City's health disparities globally. So, our role is to educate and advocate locally on issues that affect women and girls globally, and using a gender lens to advocate for health as a human right with a focus on issues such as violence against women, sexual and reproductive health and rights, early marriage, economic and political participation. So, we're going to speaking today mainly about the importance of gender assessment based on gender disaggregated data, and the planning policies the services of the Department of Health and Mental Hygiene. First, we really want to congratulate the Center for Health Equity. They do fantastic work, and I think we heard so much about it today, and your questions were wonderful to really sharpen the focus on certain aspects, which we totally agree with, their Race to Justice Initiative, the New Gender Justice Initiative, all of those are things that really put the lens on issues that we are really all concerned about. However, we feel that that Center for Health Equity needs to continue to sharpen its

focus on planning and implementation through a gender lens to add to the focus using the race—racial lens. So, we think that's really important to kind of put equal weight on both. The Center for Health Equity has produced as really wonderful comprehensive report called New York Takes Care 2020 and it reports on 26 indicators citywide by borough selected because of your importance to community and social justice, and this data has been captured by gen—by—yes, it's been collected by gender. It really has not been displayed by gender. So, what we see is data and targets that were compared to baseline by race and extreme poverty in neighborhoods. So, but—so we don't have a sense of what the gender dimensions are of that. Indicators such as obesity, physical activity, overdose deaths, mental health needs [bell] are all really needing to be looked at from a gender perspective. So, our recommendations are what Ms. Kaufman has already put forward. We really need to have gender analysis. We need to have gender disaggregated data. We would really encourage the Department of Health and Mental Health to work closely with the Commission on Gender Equity, and as you just suggested the Commission on Women's Affairs.

We think that bringing together all of these agencies and commissions that really are working towards the same goal of gender and racial justice is really important, and we would be happy to help in any way by also really contributing toward the broader global picture. Thank you.

CHAIRPERSON LEVINE: Thank you. Okay, sir. Sorry. Pinzon.

JUAN PINZON: Yes.

CHAIRPERSON LEVINE: Thank you.

JUAN PINZON: Thank you, Councilman and thank you to your colleagues as well for holding this hearing on this really important work for the Center for Health Equity. My name is Juan Pinzon. I'm the Director of Health Services at the Community Service Society. CSS has a really long history, one of 75 years to be more precise. You know, being the voice for low income and minority New Yorkers with health programs. We help people enroll in health insurance. We have the largest navigator grant from the state to help people across the state enroll in health insurance, but we also help people connect to care if they—they cannot afford insurance. We also help them understand their insurance and making sure that they

are able to access care through their insurance, and we do that primarily through programs like Community Health Advocates and Independent Consumer Advocacy Network. Altogether we save about 1,000—100,000 New Yorkers every year to these programs, and many of these New Yorkers are people of color, but I also wanted to make sure that we do this through this Health (sic) Box model, which allows us to serve consumers through a live-person help line, but we have community based organizations, and more than 50 community-based organizations underground providing these services. To day, I would like to talk more about one of the initiatives that Dr. Maybank mentioned in her testimony. This is the program called Harlem Health Advocacy Partners, which is a very unique initiative that serves five public housing developments in East Harlem. We do this with—together with the New York City Housing Authority, and also with NYU CUNY Prevention Research Center, and the goal of HHAP is to reduce health disparities related to chronic diseases particularly asthma that it is on hypertension. And since 2—2014, CSS has served almost 900—900 residents with more than 26,000 needs in this community. So, we are

recommending the city to expand the age and model to all of our high need neighborhoods that could benefit form these—from these services. The—the—the-the HR model is very new (sic) because it's guided by a health equity framework, and employs a three-pronged approached to address the needs of the administrations. So, the model combines the assistance of 20—of 12 committee health workers, 3 CSS health advocates and 5 community health organizers. The community health workers provide health coaching to residences—to residents to manage their existing health issues and set health goals for the future. Then when residents address specific barriers to health, and reach their goals by providing them access to local health and social services. The two advocates from CSS under our hand provide health insurance enrollment and plus enrollment expertise and assistance to help the residents enroll, and use the health coverage, and we work with community health workers to identify those uninsured residents, enroll them in coverage and help those who are already insured and make sure that they are able to use the coverage. Health advocates also have raised the ages—[bell] residents with questions

about the coverage. Since 2014, we have handled more than 2,600 cases, and saved residents over $170,000 in medical bills and connecting them to programs to lower their prescription drugs. So, I just—I guess I don't have time to go through my whole testimony, but wanted to end by—by saying that this is a program that we believe is already addressing the social determinants of health, and you've seen health disparities in East Harlem, and we believe this is a program that we could easily expand to our neighborhoods in—in New York City who—who need these services. So, we hope that we can work there with the Committee on Health and with the Department of Health and Mental Hygiene to make this possible. Thank you so much.

CHAIRPERSON LEVINE: Thank you. What—where are you in East Harlem? Do you have your own facility?

JUAN PINZON: So, we actually are located in the Neighborhood Health Center--

CHAIRPERSON LEVINE: [interposing] Got it.

JUAN PINZON: --East Harlem. Yeah.

CHAIRPERSON LEVINE: Okay, so you're doing navigation and—and health insurance enrollment at that site.

JUAN PINZON: Yeah. So, primarily, so 96% of the clients that we're serving actually already have health insurance. Many of them are on Medicare, Medicaid. Some of them involve Medicare and Medicaid. So, our main function is actually helping people, you know, understand their insurance--

CHAIRPERSON LEVINE: [interposing] Right.

JUAN PINZON: --make sure that they don't have any problem with the health insurance, which happens very, very often. You know, medical bills. People don't understand how to access them especially how to, you know, access prescription drugs, medical equipment. We help people with those issues.

CHAIRPERSON LEVINE: Right. So, this number I've seen is that there are 667,000 New Yorkers who lack health insurance.

JUAN PINZON: Uh-hm.

CHAIRPERSON LEVINE: That's around adults. The kids are mostly covered by Child Health.

JUAN PINZON: Child Health, yes.

CHAIRPERSON LEVINE: And many of them are undocumented immigrants--

JUAN PINZON: Uh-hm.

CHAIRPERSON LEVINE: --so that's a—that's a separate challenge that we urgently need to address.

JUAN PINZON: Right.

CHAIRPERSON LEVINE: --but there are still several hundred thousand. I don't know the exact number but, in the hundreds of thousands of New Yorkers who are eligible--

JUAN PINZON: [interposing] Right.

CHAIRPERSON LEVINE: --for in the small number of cases Medicaid--

JUAN PINZON: [interposing] Yeah.

CHAIRPERSON LEVINE: --and in a large number of cases, some subsidized insurance on the exchange.

JUAN PINZON: Uh-hm.

CHAIRPERSON LEVINE: So, what could we do to get every last one of them insured—what—that we're not currently doing?

JUAN PINZON: Well, we need—so, the state already funds the Navigator Program to help people

enroll in health insurance and it funds community health advocacies where the people have access to—to care and use their insurance, but there is not really of lot of funding to community based organizations to reach out to those people who are still uninsured. There is—currently, there's an organization called Access Health NYC, and it's a million dollars that gives some of its funding to the city also to reach out, but it's, you know, obviously not enough. So, I think what we need is, you know, more funding for community-based organizations to be able to do community presentations, do home visits, be out in the community and trying to get, you know, those vulnerable New Yorkers, people who are, you know, special immigrants who, you know, in this current climate are very concerned about accessing care, about applying for health insurance even if they're eligible. So, we really need more resources to be able to—to, you know, to do more outreach and reach these hard to reach populations.

CHAIRPERSON LEVINE: Okay. well that sounds like something we need to be investing in for sure, right. Excellent. Well, thank you, Juan and thank you to the panel.

MARY LUKE: Thank you.

JUAN PINZON: Thank you.

CHAIRPERSON LEVINE: Alright and this concludes our hearing. Thank you all very much. [gavel]

C E R T I F I C A T E

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

Date March 13, 2018