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## THE COUNCIL

# COMMITTEE REPORT OF THE HUMAN SERVICES Division

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#### September 30, 2020

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

**RESOLUTION NO. 0638-2018:**  By Council Member Eugene

**TITLE:** Resolution calling on the New York State Department of Health to create stand-alone, self-contained isolation centers or units for the treatment of patients with infectious disease due to epidemic, including highly contagious and airborne diseases

1. **Introduction**

On September 30, 2020, the Committee on Hospitals, chaired by Council Member Carlina Rivera, and the Committee on Health, chaired by Council Member Mark Levine, will hold a hearing on New York City’s plan for COVID-19 testing and contact tracing. The Committees will also hear Resolution Number 0638-2018, calling on the New York State Department of Health to create stand-alone, self-contained isolation centers or units for the treatment of patients with infectious disease due to epidemic, including highly contagious and airborne diseases, sponsored by Council Member Eugene. Among those invited to testify are representatives from Health and Hospitals (H+H), the New York City Department of Health and Mental Hygiene (DOHMH), and other interested parties.

1. **Background**

Since the novel coronavirus first emerged in late 2019,[[1]](#footnote-2) it has spread rapidly around the world. As of September 29, 2020, there have been more than 33,717,601 confirmed COVID-19 cases and more than 1,009,267 deaths worldwide, including more than 7,377,612 cases and more than 210,180 deaths in United States.[[2]](#footnote-3) New York State and New York City have been hit particularly hard by this pandemic. As of September 29, there have been more than 457,649 confirmed cases[[3]](#footnote-4) and more than 25,470 deaths in the State,[[4]](#footnote-5) including more than 238,733 cases and 19,183 confirmed deaths[[5]](#footnote-6) in New York City.[[6]](#footnote-7)

In order to slow the growth of COVID-19 cases in New York, Governor Andrew Cuomo declared a State of Emergency on March 7, and has since issued a series of orders that have closed schools, businesses, and changed the day-to-day lives of millions of New York residents.[[7]](#footnote-8) The goal of these social distancing measures was to slow the spread of coronavirus, and thereby “flatten the curve.”[[8]](#footnote-9) The primary concern for public health authorities in recommending these measures was to ensure that the number of people who required hospitalization was limited as much as possible, to put hospitals in a better position to manage a surge in cases.[[9]](#footnote-10)

In the weeks since these social distancing measures were enacted, the immediate concern regarding hospital capacity was abated as the number of new COVID-19 cases, hospitalizations, and deaths declined significantly.[[10]](#footnote-11) On May 4, Governor Cuomo announced a phased, regionally-based reopening plan for the state, set to begin on May 15.[[11]](#footnote-12) Under the plan, in order to determine whether a region can loosen restrictions, state and local officials would monitor four core factors. Phased re-openings would only occur in a region if:[[12]](#footnote-13)

* The infection rate is sufficiently low;
* The healthcare system has the capacity to absorb a potential resurgence in new cases;
* Diagnostic testing capacity is sufficiently high to detect and isolate new cases; and
* Robust contact-tracing capacity is in place to help prevent the spread of the virus.

While each of these factors is crucial, public health experts agree that a robust network of “contact tracers” are key to safely reopening the economy.[[13]](#footnote-14)

*Contact Tracing*

According to the Centers for Disease Control and Prevention (CDC), contact tracing involves public health staff working with an individual with a confirmed or suspected infection to help them recall everyone with whom they have had close contact during the timeframe while they may have been infectious.[[14]](#footnote-15) Public health staff then warn these exposed individuals, or contacts, of their potential exposure as rapidly and sensitively as possible, while keeping the identity of the infected individual private.[[15]](#footnote-16) Contact tracers also play an educational role by providing contacts with information and guidance to understand their level of risk, what to do if they are feeling unwell or begin to feel unwell, and how they can best isolate themselves to prevent further spread of the virus.[[16]](#footnote-17) Effective contact tracing includes wide scale access to testing as well as timely and complete case reporting by laboratories and medical care providers, and linking these reports to health departments’ case management systems.[[17]](#footnote-18)

While contact tracing has received significant attention because of the COVID-19 pandemic, it has been around for many years and was utilized during other outbreaks and pandemics, such as the AIDS epidemic of the 1980s and 1990s and the 2014 outbreak of Ebola.[[18]](#footnote-19) New York City has successfully done contact tracing before, with diseases like tuberculosis and measles, but the coronavirus outbreak presents significant challenges at a much larger scale, with a large number of cases across the five boroughs.[[19]](#footnote-20) As contact tracing requires knowledge and skills,[[20]](#footnote-21) New York State partnered with the Johns Hopkins Bloomberg School of Public Health and former Mayor Michael Bloomberg (through Bloomberg Philanthropies) to develop the NYS Contact Tracing Program, a robust tracing program.[[21]](#footnote-22) On May 11, Johns Hopkins released a contact tracing course online, and applicants in New York City and State were directed to take this course.[[22]](#footnote-23) New York City appears to have the biggest city-level program,[[23]](#footnote-24) hiring 3,000 disease detectives and case monitors to assist with contact tracing.[[24]](#footnote-25) New York State has 2,000 tracers working outside the city.[[25]](#footnote-26)

*DOHMH and Contact Tracing*

Under the New York City Charter, one of DOHMH’s core functions, powers, and duties is to, “supervise the reporting and control of communicable and chronic diseases and conditions hazardous to life and health.”[[26]](#footnote-27) Accordingly, DOHMH has long engaged in the reporting, control, and containment of infectious disease. DOHMH houses a Bureau of Communicable Disease, which directly monitors and controls infectious diseases, including: hepatitis, HIV/AIDS, influenza, measles, mumps, pertussis, sexually transmitted infections, tuberculosis, varicella, west Nile virus, Zika virus, zoonotic and vector-borne diseases, and novel respiratory viruses.[[27]](#footnote-28) Further in this capacity, under the New York City Health Code, medical providers are required to report certain diseases and conditions directly and immediately to DOHMH, so that the Department can enact its core function of monitoring infectious disease.[[28]](#footnote-29)

In order to effectively monitor and control infectious disease, DOHMH employs disease detectives, who investigate suspicious clusters of illness.[[29]](#footnote-30) DOHMH epidemiologists then study the patterns, causes, and effects of health and disease conditions in New York City neighborhoods.[[30]](#footnote-31)

By contrast, H+H’s core mission under the Health and Hospitals Corporation Act is the “provision and delivery of comprehensive care and treatment of the ill and infirm.”[[31]](#footnote-32)

*Contact Tracing: New York City Test and Trace Corps*

On May 8, Mayor Bill de Blasio announced the formation of the New York City Test and Trace Corps (“the Corps”), the City’s “comprehensive plan to test, trace, and treat every case of COVID-19.”[[32]](#footnote-33) The Corps is housed and run under H+H, under the leadership of Dr. Ted Long, Jackie Bray, Dr. Andrew Wallach, Dr. Jay Varma, and Dr. Demetre Daskalakis.[[33]](#footnote-34)

The Corps launched with 1,000 contact tracers in early June,[[34]](#footnote-35) and had hired 3,000 tracers by the end of June,[[35]](#footnote-36) with an initial stated goal of adding 5,000-10,000 additional employees to work in a contact tracing call center. Per current State and Federal guidelines, the contact tracing program aims to have 30 contact tracers per 100,000 residents.[[36]](#footnote-37) As part of the transfer of this work from DOHMH to H+H, DOHMH transferred its forty experienced contact tracers to H+H.[[37]](#footnote-38) Contact tracers investigate cases, trace and monitor contacts, and manage all case data and inquiries. Additionally, the Corps also ensures that individuals that are required to quarantine or isolate as part of these efforts have access to a hotel or hospital, meals, clean clothing, medical refills, laundry, groceries, pet services, or other wraparound services as needed.[[38]](#footnote-39) They also refer to telemedicine to perform remote medical checks on those in isolation and quarantine, and to evaluate individuals with symptoms to determine whether testing is appropriate.[[39]](#footnote-40) According to its website, the contact tracing program relies on partnerships with community-based organizations, local providers, and non-profits to provide “effective, culturally and linguistically appropriate services, and respond to the needs of communities that have been disproportionately affected by the COVID-19 pandemic.”[[40]](#footnote-41)

The program utilizes a contact tracing training from Johns Hopkins University,[[41]](#footnote-42) and also utilizes Salesforce to track and collect information about patients who test positive for COVID-19.[[42]](#footnote-43) Salesforce is a company that specializes in customer relationship management, and brings companies and customers together through one integrated platform.[[43]](#footnote-44) Finally, as of late July, through partnerships with local clinics and labs, the City has the capacity to test 50,000 residents per day.[[44]](#footnote-45)

*Data*

In May 2020, the New York City Council passed Introduction Number 1961-2020, sponsored by Council Member Ritchie Torres, regarding public reporting on contact tracing for COVID-19.[[45]](#footnote-46) According to Local Law 61, H+H is required to report weekly and, once practicable, daily, on the demographic breakdown of contact tracers, cases, and contacts.[[46]](#footnote-47) H+H is required to report on the number of contact tracers “disaggregated by languages spoken and zip code of residence.”[[47]](#footnote-48) Similarly, H+H is required to report numbers for cases “disaggregated by zip code, race, ethnicity, gender, age range, whether they tested positive for currently having COVID-19 or experienced COVID-19 symptoms within the last 14 days, … and whether such individuals were referred to wraparound services.”[[48]](#footnote-49) In addition, H+H is required to report weekly on cases disaggregated by “occupational setting and comorbidity.”[[49]](#footnote-50) Providing this data will allow community-based organizations (CBOs) and researchers to identify communities at risk of a spike in COVID-19 cases and ensure that the T2 program is appropriately meeting the needs of the city’s vulnerable communities[[50]](#footnote-51).

H+H has also reported cumulative and two-week averages on the number of cases and contacts who are: added to the system, have a reachable phone number, are reached for a conversation, and complete intake.[[51]](#footnote-52) The number of cases who provide contacts is also reported for each of these criteria.[[52]](#footnote-53) These metrics make it possible to identify how successful the T2 program is at reaching those confirmed or suspected to have been exposed to COVID-19, and convincing them to isolate and provide their contacts.[[53]](#footnote-54)

*Concerns About the T2 Program*

Data: Cultural Inclusivity and Identity Data

The pandemic has highlighted inequities that have long persisted in our society, including inequities based on race, socioeconomic status, religion, and immigration status, which impact the health and financial stability of many communities.[[54]](#footnote-55) For contact tracing to be effective, contact tracers must be culturally inclusive and connected to the City’s diverse and different communities, and there must also be public buy-in.[[55]](#footnote-56) Data shows that COVID-19 has disproportionately impacted lower income communities and New Yorkers who are Black and Latinx, and Black and Latinx New Yorkers are two times more likely to die from COVID-19 than their white counterparts.[[56]](#footnote-57) Additionally, those who are older are at higher risk, with numerous disturbing reports about high rates of nursing home cases and deaths.[[57]](#footnote-58) Although DOHMH has not released data to illustrate the impact on all communities, we know that communities disproportionately impacted by the pandemic include individuals who are undocumented, disabled, experiencing homelessness, and incarcerated, as well as members of the Orthodox Jewish community.[[58]](#footnote-59)

In order for data to identify harder hit populations and communities, it is essential that it is both complete and disaggregated by all demographic categories.[[59]](#footnote-60) As of the last report on September 21, H+H is only reporting data disaggregated by zip code and each demographic category individually.[[60]](#footnote-61) In addition, for many demographic categories, the majority of the data is not listed. For example, in case data for September 14, 76 percent of race data was reported as “Declined to Answer”, “Did not Identify Race,” or “Unknown” with 52 percent of all answers being “Unknown.”[[61]](#footnote-62)

Contact tracing relies on the public’s willingness to come forward if they feel ill, get tested, and disclose information about who they have come in contact with.[[62]](#footnote-63) The public must feel confident doing so, as well as trust in the services they may need in order to comply with isolation and quarantine.[[63]](#footnote-64) While the data provided by the T2 program has improved over time, there is still incomplete data and many patients do not provide contact tracers with contacts who have been potentially exposed to COVID-19.[[64]](#footnote-65) Those who do not supply contacts may not do so because they refuse, they do not have any contacts to share, or it is not medically necessary.[[65]](#footnote-66) There is also incomplete data about contact tracers.[[66]](#footnote-67) For example, while the data lists the languages spoken by contact tracers, languages that are spoken by between zero and five speakers are denoted with an asterisk for privacy reasons.[[67]](#footnote-68) Therefore, it is unclear how many contact tracers speak Afrikaans, American Sign Language, Farsi, German, Japanese, Korean, Malay, Polish, Punjabi, Yiddish, and other languages.[[68]](#footnote-69) Finally, weekly reports posted on the H+H website are not archived in a publicly-accessible fashion, so this data cannot be tracked over time.[[69]](#footnote-70)

Roll-Out and Current Hotspots

According to Resolve to Save Lives, an initiative of Vital Strategies led by the former head of the CDC and DOHMH, Dr. Tom Frieden, communication with the public is one of the key factors in a successful test and trace program.[[70]](#footnote-71) A contact tracing program should be transparent, provide accurate and timely information to all residents, and should reassure residents about their concerns and safety.[[71]](#footnote-72) Communication efforts should be partnered with community members, such as faith-based and ethnic group leaders, community leaders, business leaders, teachers, and trusted public officials, and should allow for feedback from communities to ensure their effectiveness.[[72]](#footnote-73) Communications should also be translated and available in appropriate languages.[[73]](#footnote-74)

Other concerns have been raised about the T2 program, especiallyrelated to the program’s launch.[[74]](#footnote-75) The T2 program was at first limited by a low response rate from contacts.[[75]](#footnote-76) Concerns also included issues with the work environment and training, as well as organizational issues.[[76]](#footnote-77) Concerns were raised about language competency, as tracers were marked as “bilingual” if they spoke a language other than English, but “in a move that seemed to make no sense, bilingual case investigators all had to make calls to Spanish-speakers, even if they didn’t speak Spanish, according to a July 3 email from a supervisor.”[[77]](#footnote-78) According to the T2 program, many of these issues have been addressed, and could be attributed to the newness of the program.[[78]](#footnote-79)

According to the T2 Community-Based Organization Engagement Opportunities Request for Proposals, organizations with a demonstrated ability to cover larger areas and manage additional organizers may be awarded amounts exceeding $750,000, the largest grant offered, with additional requirements scaled to match the size of the grant.[[79]](#footnote-80) Also, the City is focused on engaging CBOs with links to highly impacted communities, and staff with fluency in languages prevalent in such communities, including Spanish, Chinese, Russian, Korean, Bengali, Punjabi, Urdu, Arabic, French, Haitian Creole, Kru, Tagalog, African languages, Polish, Hindi, Yiddish, and American Sign Language.[[80]](#footnote-81)

The Committees are interested in learning more about CBO involvement, including the involvement and connection with smaller CBOs embedded within communities, as well as with language access and inclusivity, especially in light of the unclear language data provided about contact tracers and recent upticks in cases in specific neighborhoods.[[81]](#footnote-82) As of September 23, there are emerging hotspots in six neighborhoods: Williamsburg, Midwood, Borough Park, Bensonhurst, Kew Gardens, and Edgemere-Far Rockaway.[[82]](#footnote-83) The neighborhoods currently experiencing spikes in cases include ultra-orthodox Jewish communities, and it is still unclear which CBOs and community leaders have been involved in the response efforts, and how many contact tracers can communicate in Yiddish. The Committees plan to discuss how the currently available data can be improved to better identify and track potential emerging hotspots.

Data privacy is a concern held by many, especially for communities who have been and who continue to be targeted by authorities, such as immigrant communities.[[83]](#footnote-84) Mistrust among communities of color is “related to a historical legacy of mistreatment and discrimination, such as during the Tuskegee experiment, and extends to policies such as the Trump administration’s public charge rule.”[[84]](#footnote-85) Such concerns were recently highlighted in an article detailing repetitive and numerous contact tracing efforts made towards an individual living in one of the neighborhoods experiencing a spike in cases, marking the program as overly intrusive.[[85]](#footnote-86) While there is a contact tracing advisory board composed of community leaders, it seems as if their concerns, specifically related to data privacy, have been ignored.[[86]](#footnote-87) While the T2 program notes that their database will not be linked to any law enforcement databases[[87]](#footnote-88), the Council is unsure what sort of contact tracing enforcement occurs.

Test Result Turnaround Times

Over the course of the past few months, wait times for COVID-19 diagnostic test results have varied and, in many cases, have been very lengthy, resulting from spikes in COVID-19 cases across the country.[[88]](#footnote-89) New Yorkers have experienced delays at city and private sites of more than a week, although wait times at City sites tend to be shorter.[[89]](#footnote-90) According to the T2 website, COVID-19 test results are generally received “in 3-5 days if [a person] got tested at an NYC Health + Hospitals location. Results may take longer at other sites.”[[90]](#footnote-91) Delays of multiple days put more people at risk, as those who may have COVID-19 may potentially expose more people.

With schools reopening, there are twenty-two priority sites for all Department of Education students (3K through 12th Grade), employees, employees of DOE contracted early childhood programs, and affiliated family child care networks, and employees of DOE- and Department of Youth & Community Development-contracted Learning Bridges program,[[91]](#footnote-92) including some new rapid testing sites.[[92]](#footnote-93) While there are places to get tested aside from City sites, including doctors’ offices, CityMD clinics, home-test kits, and even concierge service, many medical providers rely on the same handful of private labs, which has led to delays.[[93]](#footnote-94) Recently, the City has announced the opening of its own lab that should significantly cut down on wait times.[[94]](#footnote-95) The expectation is that the lab will eventually be able to test more than 40,000 samples a day, and results will be issued in 24 to 48 hours.[[95]](#footnote-96)

1. **Conclusion**

The Committees aim to learn more about the City’s test and trace efforts, including its implementation and the administration’s collaboration with CBOs and the communities most impacted by the pandemic. The Committees plan to learn more about the roll out of the program to ensure that we are doing all we can as a City to protect New Yorkers while reopening our economy and easing social distancing guidelines.

Res. No. 638

..Title

Resolution calling on the New York State Department of Health to create stand-alone, self-contained isolation centers or units for the treatment of patients with infectious disease due to epidemic, including highly contagious and airborne diseases

..Body

By Council Member Eugene

Whereas, During the Ebola epidemic in 2014, New York State designated 8 hospitals to treat Ebola virus cases, but only Manhattan’s Bellevue Hospital isolation unit was fully operational when the first Ebola case hit the State; and

Whereas, Bellevue’s quarantine unit was developed in the 1990s when tuberculosis cases were suddenly on the rise and has special anterooms, as well as ventilation and plumbing that run separately from the rest of the hospital’s systems; and

Whereas, While Bellevue’s unit is a great resource for the City, it only has space for 4 patients; and

Whereas, Each of the 8 hospitals in the State designated to treat Ebola virus cases only had space for 2 to 4 patients; and

Whereas, The State was monitoring the spread of Ebola in other parts of the world and had months to make preparations, yet facilities were still not prepared when Ebola struck New York; and

Whereas, New York can follow the example of the National Institutes of Health’s Special Clinical Studies Unit at the Clinical Research Center in Bethesda and use its isolation units as research laboratories when not filled with patients; and

Whereas, The State may not have time to prepare for the next outbreak of an infectious disease and should ensure that facilities are in place that can contain such an outbreak; now, therefore, be it

Resolved, That the Council of the City of New York calls on the New York State Department of Health to create stand-alone, self-contained isolation centers or units for the treatment of patients with infectious disease due to epidemic, including highly contagious and airborne diseases.

CP

LS# 1881

2/27/18

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