

Committee On Health

Date	APRIL 15 2011
Start Time	1:15
Finish Time	4:15

START ON TRACK 2

**THE COUNCIL
THE CITY OF NEW YORK**

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 4/11/11

(PLEASE PRINT)

Name: Dr. Joseph Masci

Address: _____

I represent: New York City Health & Hospitals Corporation

Address: _____

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(PLEASE PRINT)

Name: Kevin C. Lo

Address: 208 Canal St.

I represent: Charles B Wang Community Health Center

Address: same as above

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(PLEASE PRINT)

Name: GRAHAM MURRAY

Address: 800 E. 174 ST. BROOKLYN NY 11230

I represent: _____

Address: _____

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(PLEASE PRINT)

Name: Henry B. Keel

Address: _____

I represent: NYU School of Medicine

Address: 550 First Ave NY NY

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I represent: _____

Address: _____

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Date: 4/11/11

(PLEASE PRINT)

Name: Monica Sweeney

Address: Assistant Commissioner, AIDS Control

I represent: DOHMH

Address: _____

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(PLEASE PRINT)

Name: Blayne Cutler

Address: Director, HIV Prevention

I represent: DOHMH

Address: _____

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Date: 4.11.11

(PLEASE PRINT)

Name: Deborah Levine

Address: National Black Leadership

I represent: COMMISSION ON AIDS

Address: _____

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(PLEASE PRINT)

Name: DANIEL RAYMOND

Address: 22 W. 27th, 5th Floor, NYC, 10001

I represent: HARM REDUCTION COALITION

Address: _____

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(PLEASE PRINT)

Name: Joseph Akima

Address: 400 Bway

I represent: APICHA

Address: 400 Bway NYC 10016

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(PLEASE PRINT)

Name: Daniel Tietz

Address: ACRIA, 230 W 38th St, 17th Fl, NY

I represent: ACRIA

Address: _____

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☐ in favor ☐ in opposition

Date: 4/11/11

(PLEASE PRINT)

Name: Eric Rude

Address: Director, office of Viral Hepatitis

I represent: DOHMH

Address: _____

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NEW YORK CITY COUNCIL
COMMITTEE ON HEALTH

OVERSIGHT HEARING:
HIV/AIDS - HEPATITIS C Co-INFECTION:
EDUCATION, PREVENTION AND TREATMENT

TESTIMONY OF

JOSEPH MASCI, M.D., FACP
DIRECTOR OF MEDICINE
ELMHURST HOSPITAL CENTER

NEW YORK CITY HEALTH AND HOSPITALS
CORPORATION

April 11th, 2011

Good afternoon Chairperson Arroyo and members of the Health Committee, I am Dr. Joseph Masci, Director of Medicine at Elmhurst Hospital Center, which is part of the New York City Health and Hospitals Corporation (HHC). I am also a Professor of Medicine - and also Preventive Medicine - at the Mount Sinai School of Medicine. On behalf of HHC, thank you for the opportunity to discuss HIV/AIDS - Hepatitis C co-infection. I will begin with an overview of HIV/AIDS services, and then discuss Hepatitis C and current treatment protocols.

All eleven HHC acute care hospitals are state-designated AIDS Centers that provide comprehensive HIV/AIDS (both inpatient and outpatient care) services to their patients to help them achieve the best possible outcomes. The centers work with pediatric and obstetrical departments to deliver the specialized HIV care that infants, children and pregnant women need. Coler-Goldwater, one of HHC's long-term care facilities, also provides specialized care to individuals with HIV who require ongoing medical care in a skilled nursing setting. Through HHC's health plan, MetroPlus, we operate a Special Needs Plan (SNP) for people living with HIV/AIDS. Lastly, any New Yorker can come to any HHC hospital or diagnostic and treatment center and quickly obtain confidential HIV testing, as well as expert treatment and counseling, regardless of his or her ability to pay or immigration status.

HHC is committed to improving patient outcomes by delivering comprehensive high quality HIV related medical care and supportive services, and by increasing access to HIV testing so that people are able to learn of their HIV infection earlier in the course of the disease and can be linked to life-prolonging treatment. HHC has been very fortunate in this endeavor over the last several years to receive considerable resources from the City Council to support an expanded routine HIV testing program. In Fiscal Year 2010, more than 188,000 individuals were tested and more than 1,750 individuals tested positive. Since the program began in 2006, more than 840,000 individuals have been tested for HIV and more than 8,400 individuals were diagnosed with HIV. Through the efforts of HHC staff, more than 60% of them were linked to HIV primary care within the month they were diagnosed, and more than 90% were linked to care within 90 days. HHC is the largest provider of HIV primary care in New York City.

It is estimated that between 15% and 30% of people who have HIV also are co-infected with Hepatitis C. The estimates vary since some people who are infected do not show symptoms of the disease and testing for Hepatitis C may not be consistent among populations.

As you know, Hepatitis C is a disease that inhibits the proper functioning of the liver and is a leading cause of death due to liver disease in the HIV infected population. Hepatitis C is one of the three most common forms of Hepatitis - the other two are Hepatitis A and Hepatitis B. HIV and Hepatitis C share some common routes of transmission. People who are at a very high risk of becoming infected with Hepatitis C are injection drug users. This is also a main source of HIV infection. It is important to recognize that it is the needle sharing behavior that transmits Hepatitis C, so high risk behaviors may also include the use of "street" hormones, getting a tattoo or body piercing

Based on SDOH clinical guidelines, the decision whether or not to treat a HIV-Hepatitis C co-infected individual must be made in consideration of several factors which include:

- Contraindications and relative contraindications to therapy. For example, persons with severe anemia (low blood counts), kidney disease or significant depression are not able to tolerate the medications. The major medication used, Interferon, can induce thoughts of suicide and severe depression even among persons without such history;
- Whether or not the patient has acute Hepatitis C;
- Likelihood of response to treatment;
- Likelihood of progression of scar tissue (fibrosis) of the liver in the absence of treatment;
- Immune system status;
- Extent of liver damage;
- Status of HIV disease. Treating the HIV will slow the progression of Hepatitis C virus, but liver disease may affect a person's ability to take the HIV medications;
- Risk for adverse effects of treatment (those that I mentioned before including severe depression or thoughts of suicide), as well as lowering of the person's white blood count, which places the person at risk for infection; lowering the red blood count causing anemia; and lowering of platelets (those cells needed for clotting) which places the person at risk for bleeding. This risk assessment becomes quite complex as persons with HIV and Hepatitis C frequently have these conditions already;
- Motivation for treatment and barriers to adherence to therapy; and
- CD4 count (T cells) to measure the immunity system. Persons with low CD4 counts are already at too high of a risk for infection and the Interferon medicine for Hepatitis C cannot be given to them since it would further lower their CD4 counts.

After this review, if it is determined that treatment may prove to be beneficial, the patient's physician should discuss the benefits and subsequent risks of various treatments. Currently, there is only one option for treatment, a special formulation of Interferon called Pegylated Interferon that requires weekly injection and Ribavirin pills that are taken daily in combination for at least one year.

The outcomes of those with HIV-Hepatitis C co-infection are considerably worse than those with Hepatitis C mono-infection. First, the HIV infection speeds the progression of liver damage from the Hepatitis C. Second, there are significantly more barriers to care and more contraindications to the medications affecting patients' eligibility to even be offered treatment for Hepatitis C. Third, there is a lack of qualified HIV-Hepatitis C experts trained to treat this population. Finally, the response rate to

- Advising those who have contact (household) with persons infected with Hepatitis to avoid sharing items that may be contaminated (such as toothbrushes and razors).
- Encouraging uninfected long term sexual partners of persons co-infected to continue to follow safe-sex guidelines to prevent transmission.
- Encouraging those seeking tattoos and body piercing to use only licensed establishments.

Of course, education and awareness are large components of any prevention strategy, whether it is for HIV or Hepatitis C. By holding this hearing, the Council is contributing to the public discourse on the growing problem of HIV Hepatitis C co-infection. I ask the City Council to help us spread the word of the importance to be tested for both HIV and Hepatitis C infection. The spread of hepatitis C is a large and underreported problem worldwide that is further compounded by HIV co-infection. I believe this topic is one that needs to be discussed in the public forum more often. I appreciate the opportunity to come before the Council to have this discussion. I conclude my written testimony with some thoughts about the impact that earlier diagnosis and therapy can have on an individual.

A healthy 25 year old man can expect to live another 53.1 years and that same man with HIV infection who is promptly diagnosed and takes HIV therapy according to SDOH guidelines can expect to live another 52.7 years. But, if he has Hepatitis C co-infection, his lifespan will be markedly reduced to only 10-30 years beyond diagnosis unless the Hepatitis C is controlled or cured. We will have the opportunity to change this outcome as we did for those with HIV infection alone, as the new diagnostic technologies and medications increasingly become available.

I would now be happy to answer any questions you have.

Testimony

Jules Levin, Executive Director/Founder, NATAP
(National AIDS Treatment Advocacy Project, NYC)
NYC City Council Health Committee Meeting on HCV/HIV Coinfection
April 11 2011

Thank you for holding this hearing.

I will begin by saying 2 quick things: last week at the majoe European Hepatitis C meeting, EASL, in Berlin, astonishing new study results were presented showing 'proof of concept' that HCV can be cured in patients with pegylated interferon. This development will have tremendous implications for the entire field of HCV across everything including awareness, testing, care, and treatment. If and when these study results are confirmed I expect many more patients will want to be tested and more will want to be treted. Two, I will at the end of my talk request funding from the City Council for a citywide hepatitis testing project & I will go into more detail at the end of this talk.

I am Jules Levin, the Executive Director and Founder of NATAP, the National AIDS Treatment Advocacy Project, based in NYC. The NATAP website is a leading resource on the internet for researchers and clinicians for HIV and hepatitis (C and B) research, treatment information, and conference coverage. NATAP has provided community-based HIV and HCV care and treatment education in NYC and throughout the USA and the Caribbean in English and Spanish language since 1996, with hundreds of symposiums in over 25 cities. When NATAP and myself initiated HCV/HIV coinfection policy, education, and advocacy in 1999, meeting with the NYC DOH, the Ryan White Council, the NYS AIDS Institute there was no awareness or understanding of HCV/HIV coinfection or its impact by anyone including the NYC DOH. In 2001 NATAP and myself launched what ended up being a 5-year project in Washington DC to have HCV language put in the Ryan White Care, I helped write the language that was initially put in the 2006 reauthorized Care Act which allows Ryan White Councils to provide funding for HCV/HIV coinfection in their regions, clinics, organizations, local governments are eligible to apply for this funding. I have had HIV for 28+ years, likely had HCV for as long. I was I think the first coinfection HCV 'cure' with pegylated interferon+ribavirin, the old standard of care therapy, back about 10 years ago. So I have been cured of HCV for about 10 years after taking a total of about 2 years on HCV therapy. By the way funding from NYC for HCV testing is slated to stop in March this year, this is outrageous, the City will comment further on this in their testimony. There is no funding for services at the public City testing sites. Testing sites in underserved communities are not doing outreach for testing of HCV, again this is outrageous. There is no system for referral for care at these testing sites. HCV prevalence in double among African-Americans in the USA compared to whites.

We have been facing an enormous tragedy with regards to HCV coinfection but also with HCV monoinfection, those who have HCV but don't have HIV. HCV has been for many years the leading cause of death in HIV except for AIDS. 75% of people with HCV in the USA are undiagnosed. Most people who test positive for HCV in NYC disappear, never followup. Coinfected have the advantage of being in care for HIV and now patients are required to be tested for HCV, although that was not required 11 years ago, care and services for coinfectd were absent 11 years ago when I started doing policy and education work, but since a lot of services have developed over the years for coinfectd in NYC. HCV monoinfection and of course coinfection very much disproportionately affects African-Americans, Latinos, poor, uneducated, former & current drug users, those on the margins of society but those who in NY we have always taken care of, 'give me the sick & uncared for'. But coinfectd have more serious hurdles as HIV accelerates HCV disease progression and HIV+ individuals have lower response rates to therapy. The vast majority of coinfectd are African-American, Latino, with a history of IVDU, and marginalized from society in many

ways. The current standard of care HCV therapy is hard to tolerate but even more difficult for coinfecting patients.

You know that NYC has always been the epicenter for IVDU for decades since the 1950s, and of course IVDU is the common cause for HCV transmission. The number of people with HCV in the USA is estimated to be anywhere from 4 million up to as high as 8 million, due to new research and drug development. We estimate 300,000 in the USA have coinfection, I estimate 70,000 coinfecting in NYC, but we have no adequate programs for surveillance so we don't know exactly how many people have HCV, so we try to very clumsily estimate. 90% of people who got HIV through IVDU also have HCV. HIV-infected patients face enormous hurdles in trying to cope with HCV for many unique reasons. HCV mono-infected people very often face also similarly very difficult hurdles, but for HIV we have an infrastructure, the Ryan White Care Act while for HCV we do not have an infrastructure for testing, care, and services that are desperately needed. I estimate we could have as many as 500,000 HCV-infected individuals in NYC, but it could be as much as 750,000, the city estimates 250,000 but that is likely an underestimate because surveillance methodology is known to be poor. I estimate a 5% prevalence of HCV in NYC, about 3% is the prevalence estimate nationally. New early research out of NYC finds a high prevalence rate for HCV among immigrant populations tested in NYC who were tested over the past year in a pilot project testing in immigrant community of various Asian countries, Africa, Egypt, Russians. The CDC had estimated \$3.5-4 million in the USA with HCV excluding some marginalized patient populations like incarcerated and homeless. It's been estimated in a study by Brian Edlin that 5 million in the USA have HCV including homeless and incarcerated, but this was before this recent research finding a high prevalence in these immigrant communities. So this unexpected finding increases our prevalence estimates in NYC, and this will be a finding I suspect in all other major cities, hence my estimate we could have as much as 8 million HCV-infected in the USA, but again as I said 75% of HCV-infected are undiagnosed. A relatively new issue that is not discussed and is neglected is the emerging problem of HCV sexual transmission among already HIV-infected MSM in NYC, and non-HIV infected individuals reported globally due to unsafe sex and exacerbated by substance abuse. This public health concern is simmering in NYC below the surface, but clearly there is a significant gay community in NYC and associated unsafe sex and drug abuse are a problem in NYC.

We face an explosive aging problem with HCV, the population infected with HCV mono-infection, also coinfecting, have in very large numbers been infected for 20 and as long as 40 years, and as a result the numbers of these older often undiagnosed often untreated, but aging people with HCV, are about to get sick with advanced liver disease and die in very large numbers. It's estimated that within 5-10 years these numbers will increase a lot, a recent published study by Gary Davis models a doubling in cirrhosis and liver cancer cases. This is a time bomb waiting to explode. It's estimated that 23% of HCV-infected patients have advanced liver disease. Last week in a major hepatitis journal again a study of patients in the VA found a doubling over the past 10 years in HCV+ individuals developing advanced HCV disease & a 20-fold increase in HCC, liver cancer, the aging of the patient population. The cost of taking care of these patients will boom. NYC's health care system will be burdened with these costs. There is an unseen cost of HCV. The public pays a lot of money for the care of these patients once they get sick, it can cost hundreds of thousands of dollars in hospital, clinic, and drug costs once an individual gets sick. It is much more cost effective to test people, link them to care, and to provide services and treatment. This hidden cost will I think increase now from \$2 billion a year to \$4-5 billion a year over the next bunch of years. The Millman report projects the direct medical cost impact of hepatitis C virus (HCV) infection on commercial and government payers over the next 20 years, concluding that total medical costs for patients with HCV infection are expected to increase from \$30 billion in 2009 to over \$85 billion in 2024. It's been projected in a study that US medical costs for HCV will almost triple for Medicare, double for Medicaid, and triple for the uninsured. Yet Medicaid and Medicare funding in NYS and NYC may get cut leaving NYC having to pick up these extra hidden costs. Surely, NYC will be forced to be up these costs. There is a new wrinkle NOW. Billions of research dollars have been poured into finding new HCV drugs that will essentially at least double the response rates to therapy. The 1st 2 new orally administered drugs will become available this year but 20 more orally administered drugs are in various stages of research and development & over the next years these drugs will become available. I estimate cure rates will at least double and for African-Americans will much more than double, even triple the rates of therapy success, the cure rates I estimate can approach 90-100% for patients who are not too sick already, for all including African-Americans &

Latinos who have suffered for years due to low response rates to current therapy, and of course to all patients who suffered with response to current therapy. We must be prepared though for this medical breakthrough, I think THE medical breakthrough of the last 100 years. We are not yet prepared in NYC nor anywhere else to integrate this breakthrough into our system. We do not have enough clinicians to care for what we expect to be a large increase in patients who want to go into care. We do not have adequate programs for desperately needed services.

We need a citywide testing program, one that incorporates several components including an awareness campaign, linkage to care and care & services in the clinic, and to target getting marginalized patients tested and into care along with support services for the patients and the clinics and clinicians, and for case managers. If we in NYC do not prepare for this, the new development will occur, it will get attention, it will get media attention & I think people will ask why NYC and other governments agencies were not prepared for this. I am recommending to the NYC Council Health Committee they provide \$3 million dollars for a NYC-wide pilot comprehensive program for awareness, testing/screening, linkage to care, clinician training, and support services. Broadly I suggest a budget:

\$400,000 for an awareness project

\$800,000 for testing/screening

\$300,000 for linkage to care

\$300,000 for clinician education and

\$1.2 million for support services for patients and clinics.

awareness: outreach to communities, particularly underserved communities including those with a history of substance abuse & marginalized minority patient populations and immigrant patient populations, through various approaches including media, community-based approaches.

testing/screening: again an emphasis on marginalized patient populations and their neighborhoods

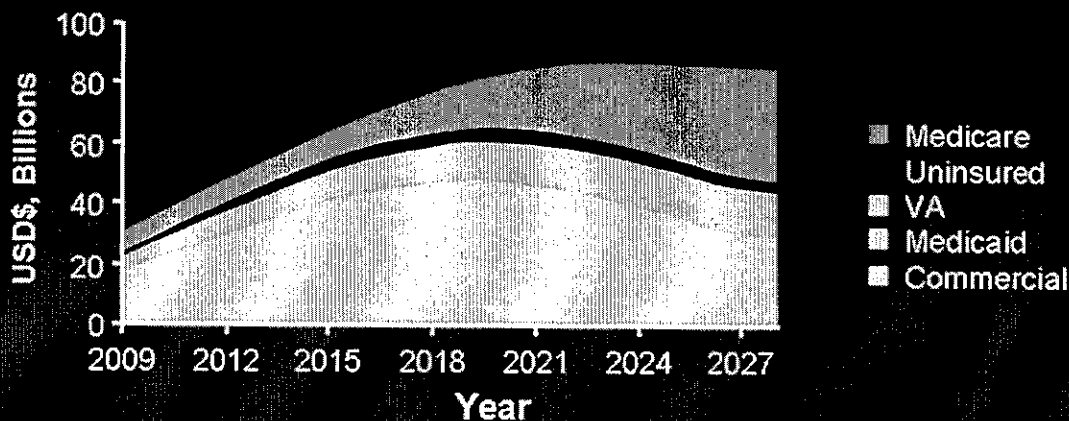
linkage to care: programs to directly take patients from testing to care

clinician education: 2 points: 1 there are very few clinicians and patients who are adequately familiar with all the new treatment paradigms being developed now related to the new oral HCV drugs nor are these clinicians adequately knowledgeable about the ongoing future expected developments in care & therapy, so this is important in making good treatment decisions; 2- there are not enough clinicians to take care of all the new patients we expect to get tested and enter care

support services for patients & clinics: patients will need education about the disease, care, and treatment; psychiatric assessments & support will be needed; support groups for patients; additional nurses & nurse training is needed; patients will need support during the pre-treatment decision making process and during treatment; if peg/RBV is used many patients will need injection assistance since they have a history of injection use, direct observed therapy; dermatology support; reimbursement support, etc.

Projected Annual US Medical Costs for Chronic Hepatitis C, 2009-2028

Assuming No Changes in Standard of Care



- Total medical costs for patients with HCV infection are expected to more than double from \$30 billion to more than \$85 billion USD over the next 20 years

The Milliman Report. Consequences of Hepatitis C Virus (HCV): May 2009. Available at:

BACKGROUND INFORMATION not to be orally presented but to be submitted as official testimony for the record, future review.

My Background

I have been HIV-infected for at least 28 years and likely had HCV for at least as long. I am probably the very first coinfection HCV cure using peginterferon+ribavirin as I was the first person to enroll in the first HCV/HIV coinfection study using peg/ribavirin which took place in San Juan. I flew to San Juan weekly initially, then every 2 weeks, then monthly, less often after that. I took a total of 2 years on treatment with interferon+ribavirin, and have been 'cured' for about 10 years. A little history, I found out I had HCV only because I realized I was at risk due to my past IVDU 30 years ago and tested at my behest, not because my doctor suggested I should be tested. Back then in about 1999 no one realized that HCV coinfection was an issue for HIV-infected people. I tested positive, went to see the head of hepatology at Cornell, had a biopsy, found out I had stage 3 disease, which is compensated cirrhosis, meaning no clinical symptoms but advanced disease just short of serious symptoms. I started interferon+ribavirin, standard interferon (IFN) because this was before there was pegylated interferon, took it for 6 months but stopped since I did not have the desired affect. I waited for peginterferon to become available. At this time, in 1999, I realized what the HIV community would be facing regarding coinfection. I was the first person to meet with the NYC DOH, to testify before the Ryan White Council in NYC, I testified several times at Ryan White Council meetings and the Health Subcommittee. Afterwards, 9 HCV/HIV Coinfection Clinics were opened at 9 NYC public hospitals and NYC HIV Care Guidelines recommended everyone with HIV should be tested for HCV. NYC was ahead of the rest of the USA. NATAP held the first large scale HCV & HCV/HIV coinfection educational symposium in NYC in 1999, over 750 people attended included clinicians and doctors from major hospitals from all over NYC, because back then no one knew about coinfection, the event was webcast live on the internet. Myself and several leading researchers & health providers spoke at this event. NATAP started a national HCV care/treatment education program, which was integrated into the HIV program, and toured to cities throughout the USA. And started a large-scale HCV, HCV/HIV coinfection NYC-based care/treatment HCV education program in both English &

Spanish language, which was integrated into the NATAP HIV citywide program, supported by grant support from the NYC DOH. Over the next 5 years NATAP held several hundred small and large workshops and forums in NYC on HCV and HCV/HIV coinfection care and treatment, in addition to many in major cities throughout the years. This program has been ongoing since, over these years over 300 events in over 25 cities in English & Spanish have been held, speakers are leading clinicians & researchers, and in the past me. In 2001 I launched what ended up being a 5-year lobbying effort in Wash DC to get HCV language into the Ryan White Care Act, I held the first HCV Briefing in Congress, held several over those 5 years, worked closely with both Republican & Democratic leaders, and helped to write the HCV language that was put in the 2006 reauthorized Care Act, for the most recent Care Act reauthorization this language was expanded. This language allows Ryan White Councils to provide funding for coinfection programs to Cities, States, clinics and other local organizations. Often around the country it is not well known by organizations that this is available.

Coinfection is a particular tragedy, Coinfection with both HIV & HCV is a much worse situation for clinicians & for patients

HIV accelerates the disease often much more quickly than for patients with only HCV, so they can get sicker much more fast & seriously, in HCV monoinfection serious disease can occur in 20-30 years but in HIV it can occur within 5-10 years, of course its variable by person. A recent study conducted at Mt Sinai Hospital in NYC finds a new serious public health problem of HCV for HIV+ MSM. They found that HIV+ MSM with HIV who get HCV-infected after HIV are at serious risk for very accelerated serious disease, very quickly. And research over the past few years research has found a new HCV epidemic in HIV+ MSM & for MSM in general, the sexual transmission of HCV. In general sexual transmission of HCV has been considered low risk, but there are certain factors that increase risk significantly including having HIV, the presence of an STD, and now this new disturbing finding is that MSM 7 HIV+ MSM in particular are at higher risk for getting HCV through sexual transmission. These studies including the Mt Sinai study find MSM are getting HCV sexually because of unsafe sex practices exacerbated by unsafe substance abuse. This concern is not receiving any public health attention in NYC. Needless to say there is a large gay community in NYC.

Coinfection has been particularly a tragedy certain specific patient populations: coinfection has always been the leading cause of death in HIV except for AIDS and I believe the data actually underestimates the morbidity & mortality rates -- for HIV-infected people, for IV drug users, for those on methadone & on opioid substitution therapy, but also for genotype 1 patients, and most particularly for African-Americans both mono & coinfectd, for Latinos as well, AND this applies to HCV monoinfected individuals/patients as well. Because the treatment is very hard to tolerate, response rates to therapy among HIV-infected patients is very low compared to HIV-negative individuals: in HIV-negatives studies, where therapy is implemented in the best case scenarios not like in real-life situations, report about 45-50% cure rates in patients with genotype 1 and 70-85% in patients with genotype 2/3. But most coinfectd patients are genotype 1, most coinfectd patients are African-American and Latino, in the USA most coinfectd patients were infected through IVDU, and most of these are African-American, and genotype 1 is extremely prevalent among African-Americans. Also recent research has shown that a certain type of gene predicts better or worse response to peg/RBV therapy, and this gene is more prevalent among AAs. The health disparities problem that cuts across race & poverty is a serious problem in HCV and coinfection, but coinfectd have the Ryan White Care Act, there is nothing for HCV monoinfected.

Because the therapy is so hard to tolerate very few patients are able to complete therapy. Most individuals who test positive for HCV in NYC are never treated. They disappear after being tested. They feel well, don't realize they are sick, have often heard bad stories about therapy side effects. For those who manage to visit a doctor or clinician they often disappear after the first visit or soon thereafter. Making the decision to start HCV therapy and actually taking the therapy is a very big hurdle, very difficult for patients. And the patient population who needs support, marginalized patients, face the biggest problems & barriers to successful care & treatment, this is particularly true for HCV monoinfected where we have little infrastructure to help these patients. The SVR (sustained Viral Response) rates among African-Americans have been between 5-25%, a recent study conducted at Montefiore Hospital in the Bronx reported similar

results. Because therapy is so difficult to tolerate special comprehensive support services are required for patients to undergo and complete therapy. These services are burdensome and expensive for patients, clinicians and clinics. BUT HCV is curable. Unfortunately another problem is that very often patients do not understand the pathogenesis of HCV disease, they don't realize that although they may feel well now, the disease can take many years, sometimes decades, to progress to serious clinical disease. However once clinical disease actually sets in it can be too late to be treated. Another key point is that HIV accelerates HCV disease progression, so although it can take many more years or up to 2-3 decades for a HCV monoinfected person to progress to serious disease it can take as short a time as 5 years for an HIV-infected person. Treating coinfecting patients is complicated by the fact that patients are also usually taking HAART, HIV multi-drug therapy.

No Services for HCV

Coinfecting patients can access support services because of Ryan White Care Act infrastructure, although they do not go on therapy often or respond well to therapy, but there is no such Federal or state program of infrastructure support for HCV. So although coinfecting patients do get some attention & services HCV monoinfected get very little.

Lets talk for a minute about HCV. Its estimated that anywhere from 4-7 million HCV-infections are in the USA. HCV prevalence has been estimated at about 2.5-3%, in the USA. But, NYC has always been the epicenter for IVDU since the 1950s and there was an explosion in NYC of IVDU into the middle class in the 1970 when heroin use had grown quite a lot. With heroin being sold widely on the streets of NYC in Brooklyn, the Bronx, Queens. But we don't have well done surveillance data in NYC or from anywhere. I estimate 70,000 people in NYC are coinfecting. I estimate there are several hundred thousand monoinfected in NYC perhaps 400,000 or more. Recent research in NYC has been testing immigrant communities for HCV and HBV, communities have people no one considered might be infected, and surprisingly this preliminary study found high prevalence rates for HCV and HBV among immigrant communities including from Russia, Egypt, Asians, the Indian peninsula. Hence it is now thought the prevalence of HCV & HBV in NYC is much higher than we thought, I am sure these findings would be also found in other major cities. The source for these findings is likely unsafe, unsanitary syringe use in medical settings in their country of origin, not IVDU. Another problem I mentioned about is sexual transmission of HCV among MSM and HIV+ MSM, where unsafe sex and concomitant drug abuse contribute to this problem.

New HCV Therapy Becoming Available Will Double Response Rates

We are about to enter a very exciting brand new era for HCV care and treatment. Over 15 new antiviral orally administered HCV drugs are in development. The first 2 drugs are HCV protease inhibitors and are expected to be approved by June 2011. While prior response rates to therapy were about 40% for genotype 1 patients with peg/RBV (peg is administered by a once weekly subcutaneous injection, ribavirin are pills taken twice daily), in optimized study conditions, phase 3 studies show 'cure' rates of 68-83% in genotype 1 patients, again in optimized study conditions. And African-Americans also show much more promising cure rates. So while this is the beginning of an era of a great medical breakthrough, it might create a seriously problematic situation for some patients; the poor and uneducated, the ones who need the therapy & to do things right to succeed the most. When these 2 new drugs come out it will I think be a mess, we don't have an infrastructure like we have in HIV, RWCA, so we don't have education and support programs for clinicians & patients. Of course the drug companies will provide some education, and in fact NATAP will be providing education on how to use these drugs but it won't be enough. I think there will be a lot of cases of misuse of the drugs, therapy failure will occur, drug resistance may result, although resistance may not be as bad as in HIV but we don't know yet what resistance with these drugs will look like, and there are very inadequate support services for patients that they will need to be successful on therapy.

Over the next 5 years it's expected a number of additional orally administered drugs will become available. We expect as in HIV multi-drug therapy regimens to be used with or without peg/RBV (research will study if these 2 drugs can be eliminated & we would have therapy consisting of 3-4 oral antiviral drugs). I expect 'cure' rates to approach 90-100% for patients that will be able to take therapy. It is I think the medical

breakthrough of the last 100 years: curing a virus with time-limited therapy. Therapy will be shortened for coinfecting and other patients, in the short-term, to 6 months for many patients instead of 12 months. In the future therapy may be shortened to as little as 12-16 weeks for some patients, but research still has to study this, but that may be the future.

At the major annual European liver conference EASL, March 31-April 2 2011 in Berlin Germany, an astonishing but not totally unexpected development in research was reported from a study that showed proof of concept that some patients perhaps all can be cured without pegylated interferon+ribavirin with only orally administered therapy. This if confirmed will have tremendous impact across the field and change everything including awareness, testing, care & treatment. More patients I expect will want to be tested & treated.

Cost

HCV care and treatment, and the drugs is not inexpensive. But care/treatment/therapy was less expensive than hospitalization. It is very expensive when a patient progressing to advanced stage liver disease. This patient enters a hospital, often a public city hospital because they are poor, and the costs to care for this person is enormous, hundreds of thousands of dollars for each person, and some may be eligible for a liver transplant. It is much less expensive, more cost effective to provide care and treatment.

During this upcoming year there will be a lot of publicity and fanfare surrounding the launch of the first 2 HCV oral drugs, the FDA approval of these drugs, and the promising much superior successful therapy rates. I am sure all the newspapers will be writing about this, researchers and companies will be raising awareness. The amount of attention paid to these developments will increase over the next few years as more therapies become available, cure rates increase.

I think it's crucial for NYC to respond to the problem now. Once the news hits the fan people will inquire what is the city of NY doing to address this problem. NYC has always been the place that takes care of the suffering and the poor. The timing is perfect now for NYC to address this problem and to be ahead of the issue and public attention.

I suggest the NYC City Council fund a program of citywide testing in NYC. This program could and should include awareness and linkage to care for those testing positive, and a prevention program to thwart new infections and spread of the disease. NYC would be ahead of any other city in the USA if they do this. NYC was the first city 10 years ago to respond to HCV coinfection with clinics and funding for programs. NATAP was the recipient of a grant from NYC to provide education & services for coinfecting. This is THE COMING health issue and will become the subject of debate nationally as well as in NYC and NY State. I recommend the NYC Council get ahead of this problem, I propose a \$3 million model hepatitis testing program for NYC to be implemented immediately. The NYC DOH and the Dept of Viral Hepatitis within the NYC DOH is poised to launch such a project. If NYC does not provide the type of programs needed here I think NYC will be left with a mess and it will be an embarrassment to NYC.

Broadly I suggest a budget:

\$400,000 for an awareness project

\$800,000 for testing/screening

\$300,000 for linkage to care

\$300,000 for clinician education and

\$1.2 million for support services for patients and clinics.

awareness: outreach to communities, particularly underserved communities including those with a history of substance abuse & marginalized minority patient populations and immigrant patient populations, through various approaches including media, community-based approaches.

testing/screening: again an emphasis on marginalized patient populations and their neighborhoods

linkage to care: programs to directly take patients from testing to care

clinician education: 2 points: 1 there are very few clinicians and patients who are adequately familiar with all the new treatment paradigms being developed now related to the new oral HCV drugs nor are these clinicians adequately knowledgeable about the ongoing future expected developments in care & therapy, so this is important in making good treatment decisions; 2- there are not enough clinicians to take care of all the new patients we expect to get tested and enter care

support services for patients & clinics: patients will need education about the disease, care, and treatment; psychiatric assessments & support will be needed; support groups for patients; additional nurses & nurse training is needed; patients will need support during the pre-treatment decision making process and during treatment; if peg/RBV is used many patients will need injection assistance since they have a history of injection use, direct observed therapy; dermatology support; reimbursement support, etc.

The San Francisco Hepatitis C Task Force Jan 24 2011 released a report expressing grave concern about the hepatitis C epidemic in the City and outlining a series of recommendations for the Mayor and Board of Supervisors to mount a comprehensive effort to fight the disease. The report, entitled "Recommendations for Strategically Addressing Hepatitis C in San Francisco" is the result of a year-long process by the Task Force to identify gaps to addressing hepatitis C in San Francisco and create a set of strategic directions for San Francisco to have an immediate impact in the following areas of hepatitis C: Research and Surveillance; Prevention, Education, Awareness and Testing; Care and Treatment; and Public Policy. Some recommendations in the document include: establishing a hepatitis C coordinator position at the San Francisco Department of Public Health; ensuring full access to hepatitis C treatment and care through Healthy San Francisco; developing citywide educational/awareness campaigns; and creating a pilot legal supervised injection facility as part of a comprehensive hepatitis C prevention strategy.

The New York City Council Committee on Health
HIV/AIDS-Hepatitis Co-Infection: Education, Prevention and Treatment
Testimony

My name is Ronni Marks. I am here today as a Hepatitis C patient and the facilitator of a Hepatitis C Patient Support Group. I'm also a Baby Boomer. The Institute of Medicine, the CDC, and other groups have recognized that Baby Boomers represent about two thirds of current Hepatitis C patients. As my generation grows older, the serious health effects of long-term Hepatitis C infection, including cirrhosis, liver failure, and liver cancer, will become a major burden on society. Improved diagnosis, treatment, and support services have the very real potential to reduce the dramatic increases in health care costs, as well as human misery, this trend is projected to cause. I appreciate the opportunity to talk with you about this emerging health crisis for people of my generation and many others.

I was diagnosed with Hepatitis C in 1997. I contracted the virus from a blood transfusion. But it doesn't matter how any of us contracted the virus, it just matters that we have a serious illness. At the time I was diagnosed, the Hepatitis C virus was newly identified and patients were virtually on their own to cope with the diagnosis and learn about their illness. There was no Internet information, no patient support groups, no advocacy organizations. I had successful careers in fashion design and executive recruiting, but after failing to respond to treatment I decided to dedicate myself to ensuring that Hepatitis C patients would not face the isolation and lack of information and support that I faced in 1997.

Since 2000, I have coordinated and facilitated the Mid-Town Manhattan Hepatitis C Support Group. The group meets at the NYU Langone Medical Center. I'm pleased that our group has become one of the largest and most successful support groups in New York City. But more groups like this one are needed

throughout the five Boroughs. As a support group facilitator and a Hepatitis C patient, I know the sense of isolation the disease can cause and the stigma we can feel. Despite being four times more prevalent than HIV/AIDS, public awareness of Hepatitis C is very, very low. The fact that Hepatitis C often does not cause symptoms for many years...until the disease has caused severe damage to the liver...may account for this lack of awareness and attention. Even many primary care physicians and other health care practitioners know little about Hepatitis C. This lack of public awareness and understanding fuels patients' sense of isolation and makes it more difficult...but also more important...for them to gain accurate information about Hepatitis C and its treatment. This year, the urgent need for improved access to information and help led me to form a non-profit organization, The Hepatitis C Mentor and Support Group, Inc., to foster the formation of patient support groups in New York and to provide patient mentoring services.

We are now on the verge of a major breakthrough in the successful treatment of Hepatitis C. In the past, only about 40 percent of Hepatitis C patients could get rid of the Hepatitis C virus through long and difficult treatment (many patients liken treatment for Hepatitis C to chemotherapy). But within the next few months, once new medications begin to become available, a much higher percentage of Hepatitis C patients will be able to eliminate the virus...to be cured. These patients will be able to lead healthy lives with a much lower risk of liver cancer or liver failure and the need for liver transplants. These cures will also reduce the spread of the virus. But the improved treatment will remain hard to tolerate and manage. In the near term, it will increase the need for medical and supportive services, including Hepatitis C patient support groups. Meeting this need will reduce long term health care costs, as well as the human toll of Hepatitis C.

Every week I receive calls from newly diagnosed Hepatitis C patients from every walk of life in New York City. They all feel the same need for accurate information about Hepatitis C and for support to manage the disease and its treatment with dignity and fellowship. Please help us increase public awareness of Hepatitis C and the promise of its successful treatment. Help us make sure that all New York City residents have access to Hepatitis C testing, treatment, and care.

Thank you.

HIV/AIDS-Hepatitis Co-Infection: Education, Prevention and Treatment

Daniel Raymond, Policy Director, Harm Reduction Coalition

April 11, 2011

Chairwoman Arroyo and distinguished members of the Health Committee, good morning. I am Daniel Raymond, Policy Director of the Harm Reduction Coalition, an advocacy and capacity-building organization focused on the health of people who use drugs. I welcome the opportunity to address a major priority for our constituents: the devastating intersection of the twin epidemics of HIV/AIDS and viral hepatitis.

New York City is the national epicenter for HIV/hepatitis co-infection. Based on city statistics, we estimate that at least one in four – and possibly as many as one in three – New Yorkers living with HIV/AIDS is co-infected with hepatitis C. Despite our tremendous progress in HIV prevention, testing, care and treatment, HIV/hepatitis C co-infection rates are dangerously high among many of our most vulnerable: those struggling with histories of addiction, poverty, mental illness, housing instability, and incarceration. We have heard countless stories of individuals who have made heroic efforts to bring their HIV under control and transform their lives, only to discover that their biggest battle – dealing with hepatitis C – still lay ahead of them. The HIV/AIDS community has already lost far too many people from end-stage liver disease, and without intervention the burden of co-infection will continue to rise.

However, there is good news on the horizon: new treatments for hepatitis C are expected to receive FDA approval in the coming months, and several more are in development. These new treatments – protease inhibitors that directly target hepatitis C – have the potential to usher in a revolution in treatment similar to the one seen in HIV treatment 15 years ago. Moreover, a rapid oral hepatitis C test is in development, and may be available for use in community settings within a year. Yet these

impressive scientific advances will only have an impact if New Yorkers have timely access to them. We need to ensure that the services and resources are in place for those who stand to benefit the most from these new tools. Failure to act will reverse the progress we've made in protecting the health of New Yorkers living with HIV/AIDS: we will see increased illness and mortality due to hepatitis co-infection as the population ages and liver damage spreads. We now have a vital window of opportunity to save lives, but the clock is ticking.

I'd like to highlight several on-going initiatives to address different components of the co-infection crisis:

- **Prevention:** the majority of people struggling with HIV/hepatitis co-infection were infected by both viruses through injection drug use. For over two decades, New York City has been a trailblazer in syringe exchange programs, with crucial support from the City Council. However, much work remains to make syringe access – and the accompanying support and social services – a reality for all in need. Later this month, we will be releasing a groundbreaking report on Peer Delivered Syringe Exchange, a new user-to-user model which holds tremendous promise as the new frontier in expanding syringe access to those hardest to reach. In addition, the Harm Reduction Coalition, in partnership with many other groups, has led the charge to remove the federal funding ban on syringe exchange imposed by Congress. We succeeded in 2009, and New York State's health department quickly moved to use the new flexibility to apply federal HIV prevention funds to syringe exchange. However, our victory is now under attack in Congress. Two weeks ago, we spearheaded a campaign to send a letter signed by over 80 organizations to Senator Schumer, calling on him to protect syringe exchange in the budget battles. We will find out tonight if we were successful; however, this is only the first round of a longer battle, and we need the City Council's support to ensure victory.
- **Testing and care coordination:** for several years, the City Council has supported the Injection Drug User Health Alliance, a citywide initiative including syringe access programs across all five

boroughs. Hepatitis C testing and medical care coordination is a core component of this initiative, linking people with histories of drug use and addiction to proper medical care. Due to the difficult fiscal environment, Council funding for this initiative has been cut by nearly 50% in recent years. However, demand for our services continues to rise. We call upon the City Council to again restore funding for the Injection Drug User Health Alliance budget this year.

- Increasing capacity at community health centers: the Harm Reduction Coalition is working with the city and state health departments and with the Community Health Care Association of New York State to increase hepatitis C prevention, testing, care and treatment in New York's community health centers, especially those centers already providing HIV care and treatment. We view these clinics, on the frontlines of serving the neediest New Yorkers, as a vital resource for meeting the challenges of HIV/hepatitis co-infection.

These initiatives are only a few of the many efforts to mobilize a response to HIV/hepatitis co-infection. The considerable passion, expertise and resourcefulness of the community confronting co-infection are enormous assets for New York. But we face a stark reality: a piecemeal, fragmented response to the co-infection crisis will be inadequate to the challenges which lie ahead. We need a comprehensive strategy, with the leadership and resources to make a difference.

Another city, San Francisco, confronted these same issues. In San Francisco, the mayor convened a hepatitis C task force, appointing 32 members including medical and social service providers, public health officials, hepatitis C advocates, people living with and affected by hepatitis C, and other stakeholders and experts. The task force released a comprehensive report and set of recommendations in December, which are now under review for implementation. We need this high-level leadership and coordination to develop a comprehensive co-infection strategy in New York.

Moreover, we need the support and engagement of the City Council to protect the most vulnerable New Yorkers living with HIV/AIDS. We ask for your continued attention to the co-infection crisis, and the resources we need to save lives and protect our communities.

Thank you for your time and the opportunity to provide testimony on this pressing issue.



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TESTIMONY

of the

National Black Leadership Commission on AIDS, Inc.

Before the

New York City Council Committee on Health

"HIV/AIDS-Hepatitis Co-infection: Education, Prevention and Treatment"

250 Broadway, 16th Floor

New York, NY 10007

Monday, April 11, 2011

1:00 p.m.

Chairwoman Arroyo, Members of the New York City Council Committee on Health, ladies and gentlemen, I am C. Virginia Fields, President and CEO of the National Black Leadership Commission on AIDS, Inc. (NBLCA). Founded in 1987, the National Black Leadership Commission on AIDS, Inc. is the oldest and largest policy development and advocacy not-for-profit organization of its kind in the United States whose mission is to *educate, organize, and empower* Black leaders to fight HIV/AIDS and other health disparities in their local communities. We have established affiliate chapters in 11 cities, nationwide, six of them in New York State, including New York City.

I thank the committee for providing my organization and others with the opportunity to testify before you this afternoon about the devastating impact of HIV/AIDS, Hepatitis, and other co-factors on New York City's Communities of Color, especially among African Americans and Latinos.

This year marks the 30th anniversary of the HIV/AIDS epidemic in the United States, as first recognized by the Centers for Disease Control and Prevention (CDC). Although we have made remarkable progress in the fight against HIV/AIDS over the past three decades, African Americans, approximately 13% of the nation's total population, still account for **48%** of new AIDS cases and an estimated **45%** of new HIV infection cases as of 2008, according to the CDC.

Similarly, epi-data from the New York City Department of Health and Mental Hygiene illustrate the ongoing, disproportionate burden of the HIV/AIDS epidemic on Black New Yorkers who account for **48%** of all HIV diagnoses, **51%** of all AIDS diagnoses, **45%** of all persons living with HIV/AIDS, and **52%** of all AIDS-related deaths in New York City, as of December 31, 2009.

Madam Chair, I thank the New York City Council for its strong support for programs and funding benefitting the work of the National Black Leadership Commission on AIDS here in New York City through the Communities of Color Faith Initiative. However, I urge the Council to resist efforts to undermine the effectiveness of HIV/AIDS and Hepatitis prevention, treatment and care programs, targeting African American and other communities of color, through draconian budget cuts. HIV/AIDS and its co-factors, including rising rates of Hepatitis infections, remain a public health crisis for communities of color here in New York City and nationwide. Communities of color require dedicated funding streams that support culturally competent, science-based prevention, specifically, as well as treatment and care.

As we look at the co-factors feeding the HIV/AIDS and Hepatitis epidemics, it is imperative that we adopt effective structural interventions to address these and other concomitant epidemics of diseases in our communities, including other sexually transmitted infections, as well as widening health disparities. The National Black Leadership Commission on AIDS, through its Leadership Mobilization Model, has successfully mobilized Black communities and facilitated collaborative partnerships among a diverse cadre of Black leaders, other community stakeholders, health practitioners, departments of health, elected officials, and social policy experts, among others.

Now, I am pleased to introduce Deborah Levine, the NBLCA's Vice President for Community Development, who will brief you on our organization's work with faith-based institutions and community-based organizations across the five boroughs.

Good afternoon. I am testifying this afternoon, to give you the highlights of our New York City Council Communities of Faith Initiative, which is comprised of over 66 houses of worship and 27 community based organizations that provide HIV testing, prevention, treatment and care services in all five boroughs of the City. I thank you for the opportunity to testify before you today.

The NBLCA's New York City Council Communities of Faith Initiative is a model program for improving health outcomes in high-risk African-American communities in New York City. By building the capacity of faith leaders and other key community stakeholders and faith leaders, and connecting them in a continuum of HIV education, prevention, testing and care, we leverage the reach and comparative strengths of community-based organizations (CBOs), faith-based organizations (FBOs), the New York City Department of Health and Mental Hygiene, and the New York City Council.

Strategy for Social Change: In partnership with the New York City Council and the New York City Department of Health and Mental Hygiene, NBLCA provides grants and technical assistance to a network of FBOs and CBOs in the five boroughs of New York City. Funded **community-based organizations** are linked to specific **faith-based organizations** in order to provide critical support and technical assistance. The driving goals of this project are to: (1) build the capacity of the FBOs to operate effective health ministries and HIV prevention programs; (2) establish and strengthen linkages between the FBOs and the CBOs to increase HIV testing, counseling and referral services; (3) develop a cadre of new community leaders; and (4) foster partnerships among all community stakeholders to address the challenges posed by this epidemic in African-American communities across New York City. The initiative's most notable outcomes are:

- Increased resource and service linkages between faith-based and community-based organizations;
- Increased community HIV/AIDS prevention information highlighting testing and prevention strategies;
- Increased communication and collaboration between the Department of Health & Mental Hygiene, participating clergy, community-based organizations and other stakeholders;
- Increased community awareness of HIV/AIDS services and individual HIV status

We are aware of the fiscal challenges posed to the Council due to slow economic growth and budget cuts. However, HIV/AIDS and Hepatitis in our communities won't be slowed by our weak economy. Funding cuts to vital prevention, testing treatment and care programs, such as those provided through the Faith-Based Initiative, will only add fuel to a fire that is already raging out of control. We are running neck and neck in New York City with this epidemic.

Strong religious leadership in the response to HIV and Hepatitis will not only galvanize the City's response at a critical moment in this epidemic, but create greater awareness and more accurate information and perceptions by and about faith communities and ecumenical leaders in relation to HIV and AIDS.

Testimony

of

M. Monica Sweeney, M.D., M.P.H.
Assistant Commissioner for the Bureau of HIV/AIDS Prevention and Control
New York City Department of Health and Mental Hygiene

before the

New York City Council Committee on Health

regarding

HIV/AIDS-Hepatitis Co-Infection: Education, Prevention and Treatment

April 11, 2011

250 Broadway
New York City

with blood of an infected person. People who are likely to have chronic hep C include those who received a blood transfusion before 1992 and past or current injection-drug users. There is no vaccine to prevent hepatitis C. There is medical treatment available for hepatitis C which can sometimes eliminate the virus from the body or slow the progression to chronic liver disease. Both viral hepatitis B and C are leading causes of chronic liver disease such as cirrhosis, liver cancer, or liver failure

Because both chronic hepatitis B and hepatitis C are often asymptomatic, many people who have these infectious and potentially fatal diseases are unaware of their status until they have advanced liver disease including liver cancer, which may be 20 – 30 years after the initial infection. As many as 232,000 New York City residents are estimated to be living with either chronic hepatitis B or C: approximately 129,000 New York City residents with chronic hepatitis C infection and the remaining 103,000 residents have chronic hepatitis B infection. The Health Department recognizes the enormous scope of the viral hepatitis epidemic and its disproportionate impact on City residents already affected by serious health and socio-economic issues. It is clear that New York City, as the center of the HIV/AIDS epidemic, is also the center of the viral hepatitis epidemic, and the extent of burden of both diseases has yet to be felt. Viral hepatitis B and C are both under-diagnosed. Appreciating the unique challenges of this issue, Commissioner Farley met with a 30-member committee of viral hepatitis experts and community leaders in 2010. The Commissioner has since directed staff to develop an accurate estimate of new infections so we can understand the true impact and most effectively direct our public health efforts.

The Health Department has expanded its HIV testing efforts with special emphasis on areas with high prevalence and concurrency rates. In 2008, we launched *The Bronx Knows* together with a cadre of community partners; this is the largest municipal testing scale-up in the city's history, which to date has conducted over 400,000 voluntary HIV tests in the Bronx. And, at the end of last year, Mayor Bloomberg helped us launch *Brooklyn Knows*, which aims to test the estimated 580,000 Brooklyn residents who have never been tested for HIV and link positive individuals to quality care and support services. Additionally, all nine of the Health Department's STD clinics offer voluntary, routine HIV screening to patients free of charge. Many also offer voluntary hepatitis C screening for individuals meeting specified criteria, such as those who ever injected drugs – even if only one time – have a history of liver disease, a tattoo or body piercing by a non-professional, are HIV positive, had a transfusion or transplant before 1992, been on long term hemodialysis, or had unprotected sex with someone who has hepatitis C or ever injected drugs. In 2010, STD clinics conducted almost 600 hepatitis C tests. In our effort to combat the viral hepatitis epidemic, over 15,000 hepatitis A and B vaccination doses were distributed last year for City residents at high risk for Hepatitis B infections in a variety of settings, including correctional facilities, STD clinics, needle exchange programs and HIV prevention programs. In addition, over 16,000 doses of Hepatitis B vaccine were administered to adults in the Immunization clinics. This vaccination is targeted for adults who are uninsured or seen at Health Department clinics and are administered for free.

The Health Department provides direct support to all New York State licensed syringe service programs in New York City through generous funding from the City Council. City Council funds not only subsidize the very successful public health intervention of direct syringe

Department also organizes several Hepatitis C Task Forces and a city-wide Hepatitis B Coalition to increase the resources available in the community, and provides viral hepatitis training both on-site and in various venues, including regional HIV and STD training centers.

City Council members expressed the importance of this issue, HIV/AIDS-Hepatitis co-infection, and the personal impact the epidemic has within their own districts. To that end, Council Member Arroyo, Chair of the Health Committee, along with Council Members Chin and Koo sponsored a ground-breaking Hepatitis Awareness Breakfast last October to educate lawmakers and the public on this issue. We welcomed the opportunity to participate in that event and look forward to future collaborations with the City Council.

Though the Health Department focuses many of its energies on HIV/AIDS-Hepatitis co-infection, there are still many challenges. Along with the rest of the country, we have had to act to reduce many services, including already scarce viral hepatitis services in the wake of budget cuts. Several years ago, the Ryan White Planning Council cut funding for all hepatitis C programs provided for HIV co-infected persons.

While our hepatitis A and B vaccination program provides tens of thousands of free doses of vaccine to many New York City residents who need it most, the Federal government has discontinued the funding that we used to provide hepatitis B vaccine to thousands of individuals on Rikers Island. Grant funds that were once used to sustain already limited hepatitis B and C testing have dried up, and we can no longer provide this service, even as a new rapid hepatitis C test has been approved by the FDA that would make testing both easier and more economical.

then stretch our collective budgets and collaborate on the most effective approach to provide prevention and treatment services to those most affected.

Both the Institute of Medicine and HHS recommend that people at risk for viral hepatitis be educated in prevention techniques and be tested and linked to critical services before the disease exerts its greatest possible impact on the health care system. Controlling the continuing HIV/AIDS epidemic and number of hepatitis infections requires a coordinated effort at the federal, state and local levels. Unfortunately, today's fiscal climate is further constraining an already limited pool of available public health funding. Although these services are costly, an early investment can soften the blow in the future of even more costly liver disease treatment and transplant surgery resulting from viral hepatitis and those co-infected with HIV/AIDS. With this in mind, it is our collective responsibility to direct resources as efficiently and effectively as possible to control these diseases. The Health Department appreciates the Speaker's and the Council's commitment to this issue.

I am happy to answer any questions you may have at this time.

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NEW YORK CITY COUNCIL
COMMITTEE ON HEALTH

OVERSIGHT HEARING:
HIV/AIDS - HEPATITIS C Co-INFECTION:
EDUCATION, PREVENTION AND TREATMENT

TESTIMONY OF

JOSEPH MASCI, M.D., FACP
DIRECTOR OF MEDICINE
ELMHURST HOSPITAL CENTER

NEW YORK CITY HEALTH AND HOSPITALS
CORPORATION

April 11th, 2011

Good afternoon Chairperson Arroyo and members of the Health Committee, I am Dr. Joseph Masci, Director of Medicine at Elmhurst Hospital Center, which is part of the New York City Health and Hospitals Corporation (HHC). I am also a Professor of Medicine - and also Preventive Medicine - at the Mount Sinai School of Medicine. On behalf of HHC, thank you for the opportunity to discuss HIV/AIDS - Hepatitis C co-infection. I will begin with an overview of HIV/AIDS services, and then discuss Hepatitis C and current treatment protocols.

All eleven HHC acute care hospitals are state-designated AIDS Centers that provide comprehensive HIV/AIDS (both inpatient and outpatient care) services to their patients to help them achieve the best possible outcomes. The centers work with pediatric and obstetrical departments to deliver the specialized HIV care that infants, children and pregnant women need. Coler-Goldwater, one of HHC's long-term care facilities, also provides specialized care to individuals with HIV who require ongoing medical care in a skilled nursing setting. Through HHC's health plan, MetroPlus, we operate a Special Needs Plan (SNP) for people living with HIV/AIDS. Lastly, any New Yorker can come to any HHC hospital or diagnostic and treatment center and quickly obtain confidential HIV testing, as well as expert treatment and counseling, regardless of his or her ability to pay or immigration status.

HHC is committed to improving patient outcomes by delivering comprehensive high quality HIV related medical care and supportive services, and by increasing access to HIV testing so that people are able to learn of their HIV infection earlier in the course of the disease and can be linked to life-prolonging treatment. HHC has been very fortunate in this endeavor over the last several years to receive considerable resources from the City Council to support an expanded routine HIV testing program. In Fiscal Year 2010, more than 188,000 individuals were tested and more than 1,750 individuals tested positive. Since the program began in 2006, more than 840,000 individuals have been tested for HIV and more than 8,400 individuals were diagnosed with HIV. Through the efforts of HHC staff, more than 60% of them were linked to HIV primary care within the month they were diagnosed, and more than 90% were linked to care within 90 days. HHC is the largest provider of HIV primary care in New York City.

It is estimated that between 15% and 30% of people who have HIV also are co-infected with Hepatitis C. The estimates vary since some people who are infected do not show symptoms of the disease and testing for Hepatitis C may not be consistent among populations.

As you know, Hepatitis C is a disease that inhibits the proper functioning of the liver and is a leading cause of death due to liver disease in the HIV infected population. Hepatitis C is one of the three most common forms of Hepatitis - the other two are Hepatitis A and Hepatitis B. HIV and Hepatitis C share some common routes of transmission. People who are at a very high risk of becoming infected with Hepatitis C are injection drug users. This is also a main source of HIV infection. It is important to recognize that it is the needle sharing behavior that transmits Hepatitis C, so high risk behaviors may also include the use of "street" hormones, getting a tattoo or body piercing

Based on SDOH clinical guidelines, the decision whether or not to treat a HIV-Hepatitis C co-infected individual must be made in consideration of several factors which include:

- Contraindications and relative contraindications to therapy. For example, persons with severe anemia (low blood counts), kidney disease or significant depression are not able to tolerate the medications. The major medication used, Interferon, can induce thoughts of suicide and severe depression even among persons without such history;
- Whether or not the patient has acute Hepatitis C;
- Likelihood of response to treatment;
- Likelihood of progression of scar tissue (fibrosis) of the liver in the absence of treatment;
- Immune system status;
- Extent of liver damage;
- Status of HIV disease. Treating the HIV will slow the progression of Hepatitis C virus, but liver disease may affect a person's ability to take the HIV medications;
- Risk for adverse effects of treatment (those that I mentioned before including severe depression or thoughts of suicide), as well as lowering of the person's white blood count, which places the person at risk for infection; lowering the red blood count causing anemia; and lowering of platelets (those cells needed for clotting) which places the person at risk for bleeding. This risk assessment becomes quite complex as persons with HIV and Hepatitis C frequently have these conditions already;
- Motivation for treatment and barriers to adherence to therapy; and
- CD4 count (T cells) to measure the immunity system. Persons with low CD4 counts are already at too high of a risk for infection and the Interferon medicine for Hepatitis C cannot be given to them since it would further lower their CD4 counts.

After this review, if it is determined that treatment may prove to be beneficial, the patient's physician should discuss the benefits and subsequent risks of various treatments. Currently, there is only one option for treatment, a special formulation of Interferon called Pegylated Interferon that requires weekly injection and Ribavirin pills that are taken daily in combination for at least one year.

The outcomes of those with HIV-Hepatitis C co-infection are considerably worse than those with Hepatitis C mono-infection. First, the HIV infection speeds the progression of liver damage from the Hepatitis C. Second, there are significantly more barriers to care and more contraindications to the medications affecting patients' eligibility to even be offered treatment for Hepatitis C. Third, there is a lack of qualified HIV-Hepatitis C experts trained to treat this population. Finally, the response rate to

- Advising those who have contact (household) with persons infected with Hepatitis to avoid sharing items that may be contaminated (such as toothbrushes and razors).
- Encouraging uninfected long term sexual partners of persons co-infected to continue to follow safe-sex guidelines to prevent transmission.
- Encouraging those seeking tattoos and body piercing to use only licensed establishments.

Of course, education and awareness are large components of any prevention strategy, whether it is for HIV or Hepatitis C. By holding this hearing, the Council is contributing to the public discourse on the growing problem of HIV Hepatitis C co-infection. I ask the City Council to help us spread the word of the importance to be tested for both HIV and Hepatitis C infection. The spread of hepatitis C is a large and underreported problem worldwide that is further compounded by HIV co-infection. I believe this topic is one that needs to be discussed in the public forum more often. I appreciate the opportunity to come before the Council to have this discussion. I conclude my written testimony with some thoughts about the impact that earlier diagnosis and therapy can have on an individual.

A healthy 25 year old man can expect to live another 53.1 years and that same man with HIV infection who is promptly diagnosed and takes HIV therapy according to SDOH guidelines can expect to live another 52.7 years. But, if he has Hepatitis C co-infection, his lifespan will be markedly reduced to only 10-30 years beyond diagnosis unless the Hepatitis C is controlled or cured. We will have the opportunity to change this outcome as we did for those with HIV infection alone, as the new diagnostic technologies and medications increasingly become available.

I would now be happy to answer any questions you have.

Testimony

Hearing
New York City Council
Committee on Health
Oversight - HIV/AIDS and Hepatitis Co-Infection: Education, Prevention and Treatment
Monday, April 11, 2011

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program, we have been providing antiviral treatment for hepatitis C to active injection drug users. Our SVR rate to date is 71%. That is, 71% of those we treated for hepatitis C are now free of the virus. When we remove the barriers that keep people from starting, adhering to, and finishing antiviral treatment, we can successfully treat hepatitis C even in people actively injecting drugs.

We know from research on HIV and other conditions in disadvantaged populations that multicomponent, multidisciplinary interventions are necessary to address complex problems in vulnerable populations. Our research has reinforced this message.

New antiviral drugs (protease inhibitors) are likely to become available in the coming months that will improve response rates and shorten the duration of therapy. These advances, together with the findings from our research and others' on successful approaches with vulnerable populations, provide us with new opportunities.

We are now poised to make a big impact on the hepatitis C epidemic.

Doing so, however, will require moving quickly, to take advantage of the opportunity we have now before further spread of the epidemic and further disease progression in those infected makes it too late.

It will also need to be done strategically. We know from our research and others' that comprehensive, integrated interventions are necessary to address complex problems in vulnerable populations.

NYC Responds to Viral Hepatitis

Last fall, the Department of Health and Mental Hygiene convened an expert advisory group of 30 scientific, medical, and community leaders from across the city to meet with the Commissioner of Health and convey our findings to him about the state of the viral hepatitis epidemics in New York. We told him that accelerated efforts are now needed in surveillance, prevention, testing, care, treatment, and research. The most urgent need for New York City at this time is a comprehensive program to test New Yorkers for hepatitis B and C and provide linkage to care for those testing positive and prevention services for those testing negative. This is the only way to effectively stem the extraordinary toll of illness and death these epidemics are anticipated to inflict.

The attached budget and graphic provide more details on what is needed. An effective response to the viral hepatitis needs to use methods that have proven effective at reaching and engaging those at highest risk for these infections. These populations include the uninsured and underinsured, ethnic minorities, veterans, immigrant populations, the homeless, the incarcerated, persons who inject drugs or use other illicit drugs, men who have sex with men, sex workers, high-risk youth, and persons affected by mental illness.

NYC Responds to Viral Hepatitis

Affected Populations

- Insured
- Uninsured
- Veterans
- Ethnic Minorities
- Immigrants
- Homeless
- Incarcerated
- Injection Drug Users
- Illicit Drug Users
- High-Risk Youth
- Sex Workers
- Men Having Sex with Men
- Mentally Ill

Comprehensive,
Continuing,
Integrated Care

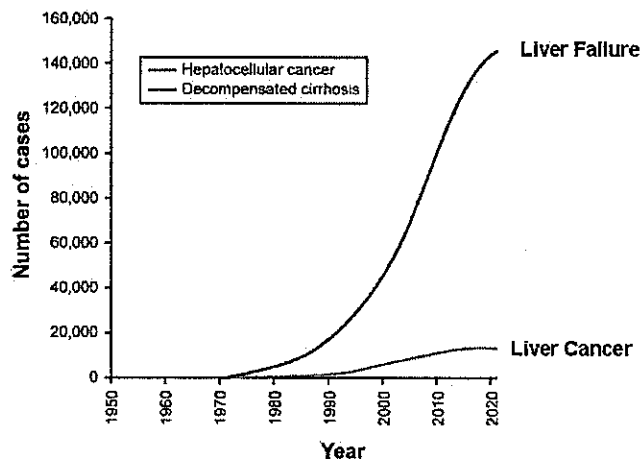
Linkage

Prevention
Services

Services

- Primary Care
- Specialty Care
- Mental Health Care
- Substance Use Treatment
- Health Insurance
- Social Services
- Case Management
- Vaccination
- Outreach and Education
- Testing
- Sterile Syringe Access
- Peer Support
- Substance Use Prevention

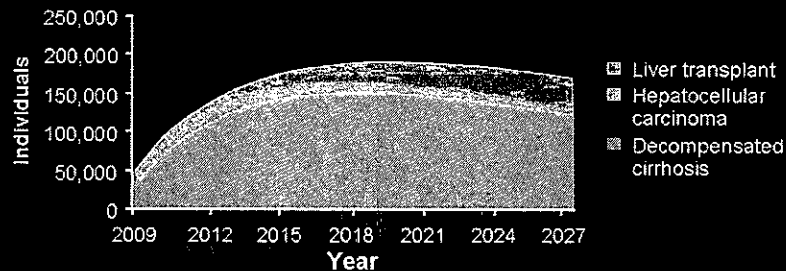
Projected Number of Cases of Liver Failure and Liver Cancer, United States



Davis *et al.* Gastroenterology 2010; 138:513-21.

Advanced Liver Disease in Chronic HCV-Infected US Population, 2009-2028

Assuming No Changes in Standard of Care

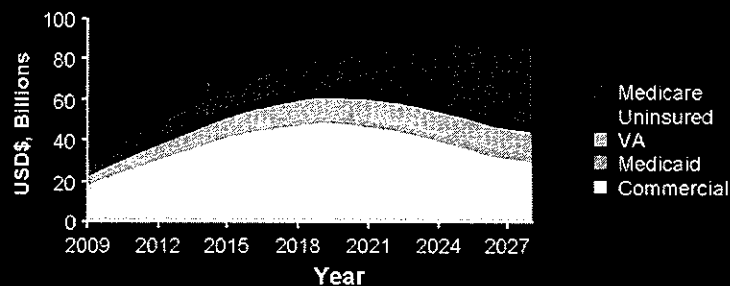


• The total number of patients with advanced liver disease is projected to increase > 4-fold in the next 20 years

The Milliman Report. Consequences of Hepatitis C Virus (HCV). May 2009. Available at:

Projected Annual US Medical Costs for Chronic Hepatitis C, 2009-2028

Assuming No Changes in Standard of Care



• Total medical costs for patients with HCV infection are expected to more than double from \$30 billion to more than \$85 billion USD over the next 20 years

The Milliman Report. Consequences of Hepatitis C Virus (HCV). May 2009. Available at:

City Council Health Committee Hearing
On the Co-Infection of HIV and Hepatitis
**Speaker: Kevin C. Lo on behalf of the
Charles B. Wang Community Health Center**

My name is Kevin Lo and I am a native New Yorker and a second generation Chinese American who has worked in public health for over 10 years. Currently, I continue to serve my community as the Program Manager for Hepatitis B Programs at the Charles B. Wang Community Health Center (the Health Center).

The burden of chronic hepatitis B (CHB) is disproportionately higher in Asian Americans who represent 4.5 million of the U.S. population, yet account for more than half of people living with chronic hepatitis B viral infection.¹ In 2007, the New York State Department of Health reported Asian Americans accounted for approximately half of the CHB cases.² According to the recently released 2010 census, Asian Americans represent nearly 13 percent of the population in New York City³ having grown 32% between 2000 to 2010, in comparison to a 2.1% growth for the general NYC population⁴. At the Health Center, 20-30% of patients screened test positive for hepatitis B. The Institute of Medicine report on Hepatitis and Liver Cancer cites studies that show routine testing for hepatitis B is cost effective. Yet two-thirds of chronically infected Asian Americans are unaware of their status because they have not been tested. However, with education, screening and vaccination many cases can be prevented. Routine monitoring of chronic patients can prevent liver cancer and cirrhosis.

Treatment of hepatitis B for a patient on medication can cost approximately \$10,000 per patient per year. The cost and lack of availability of services causes a barrier for uninsured, low-income patients. In 2008, the New York City Council discontinued \$1.5 million in funding to the Asian American Hepatitis B program. The Health Center was a major partner in this program. The end of funding has forced the Health Center to cancel community screenings and vaccination programs. We have been able to raise some foundation funding to treat 450 uninsured patients with chronic Hepatitis B infections, but we have more than 2,000 active patients in our Hepatitis B registry and 100 priority patients on our waiting list who need treatment. Moreover, we know that foundation funding is not a sustainable solution to the need for affordable care for uninsured Hepatitis B patients.

For many Asian Americans, hepatitis B transfers from mother to baby during birth or from one individual to another during early childhood. The Health Center and the New York City Department of Health Perinatal Hepatitis B Prevention Unit have worked together for many years to screen, educate and vaccinate household contacts of expectant mothers who need culturally and linguistically appropriate care. This valued relationship was challenged when the New York City Department of Health discontinued hepatitis B testing. Due to the importance of

¹ [http://www.iom.edu/~media/Files/Report%20Files/2010/Hepatitis-and-Liver-Cancer-A-National-Strategy-for-Prevention-and-Control-of-Hepatitis-B-and-](http://www.iom.edu/~media/Files/Report%20Files/2010/Hepatitis-and-Liver-Cancer-A-National-Strategy-for-Prevention-and-Control-of-Hepatitis-B-and-C/Hepatitis%20and%20Liver%20Cancer%202010%20Report%20Brief%20for%20Providers.pdf)

[C/Hepatitis%20and%20Liver%20Cancer%202010%20Report%20Brief%20for%20Providers.pdf](http://www.iom.edu/~media/Files/Report%20Files/2010/Hepatitis-and-Liver-Cancer-A-National-Strategy-for-Prevention-and-Control-of-Hepatitis-B-and-C/Hepatitis%20and%20Liver%20Cancer%202010%20Report%20Brief%20for%20Providers.pdf)

² http://www.health.state.ny.us/diseases/communicable/hepatitis/docs/chronic_hepatitis_b_and_c_annual_surveillance_report_2008.pdf

³ <http://www.nyc.gov/html/dcp/pdf/census/nyc20001.pdf>

⁴ <http://www.aafny.org/cic/briefs/newyorkbrief.pdf>



Founded in 1989

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Testimony before the New York City Council Health Committee

April 11, 2011

Council Member Maria del Carmen Arroyo, Health Committee Chair, members of the Committee, ladies and gentlemen: good afternoon. My name is Joey Akima, Project Manager, HIV Counseling, Testing, Referrals Manager of Asian & Pacific Islander Coalition on HIV AIDS. I am here today on behalf of Chief Medical Officer Dr. Robert Murayama and of all of us as APICHA. Thank you for the opportunity to testify on “HIV/AIDS-Hepatitis Co-Infection: Education, Prevention and Treatment.

APICHA is a health center located in Chinatown. Our primary target populations are Asians, people with HIV and LGBT individuals. In view of the populations we serve, we integrated STD and Hepatitis services into our medical practice. We aggressively screen our patients for STIs regardless of HIV status, and have routinized HIV testing for our HIV negative patients. When we test for STIs we have implemented a protocol which calls for routine screening for the presence of pharyngeal, anal and urethral gonorrhea and Chlamydia and also for aggressively testing our patients for syphilis. In addition, we screen for Hepatitis A, B and C and provide vaccinations against Hepatitis A and B when we find patients are susceptible, regardless of risk. We have taken an aggressive approach to treating Hepatitis B and C. We attempt to cure people with Hepatitis B whenever possible using interferon, the same medication used to treat our Hepatitis C co-infected patients. An injection medication, interferon can be curative as opposed to the suppressive approach commonly used by the medical community.

providers with the necessary training and support and encourage them to adopt a more aggressive screening protocol for Hepatitis B and C infections.

2. Expand immunization programs and intensify prevention activities targeting Asian, LGBT and other populations at high risk for Hepatitis B and C.
3. Funding for STD and Hepatitis is needed for people who are uninsured and for community health centers to provide prevention education and outreach.

About APICHA

Founded in 1989 as an all-volunteer grassroots organization with HIV prevention focus, APICHA evolved over the years into a patient-centered medical home (PCMH) providing comprehensive primary care to Asian and Pacific Islanders, LGBTQ people and people living with HIV/AIDS. Using the foundation of our culturally competent HIV Medical Care Model, APICHA has adapted that model to manage other medical conditions affecting the populations we serve. In maintaining a holistic patient-centered approach to care, APICHA has created a unique space for marginalized and vulnerable individuals.

Over 2,500 patients were served by APICHA agency-wide in 2010: more than 75% of our patients come from communities of color. In addition, APICHA continues to serve primarily Lesbian, Gay, Bisexual and Queer (LGBQ) individuals, as 53% of its clients identified as LGBQ. Of those clients with known poverty status, 41% are below the 100% federal poverty level and 16% below 200% federal poverty level, making a total of 57% of our clients low-income or poor.

The LGBT population is more likely to acquire Hepatitis A and C. According to the CDC, Approximately 10 % of new Hepatitis A and 20% of all new Hepatitis B infections in the United States are among men who have sex with men. Many men have not been vaccinated against viral Hepatitis, despite the availability of safe and effective vaccine.

Thank you, once again for the opportunity to testify today. We hope this testimony will contribute to New York City's efforts to achieve better health outcomes for A&PIs, LGBT and other New York City residents who are at high risk for HIV and Hepatitis.

March 30, 2011

Honorable Charles Schumer
U.S. Senate
Washington, DC 20510

Dear Senator Schumer,

We are writing to urge you to reject attempts to reinstate the ban on use of federal funds for syringe exchange. Syringe exchange programs have been instrumental in reducing HIV rates in New York, and enjoy broad support from state and local health departments and the communities they serve. Two decades of syringe exchange experience in New York, backed by volumes of research, have established that these programs are vital to protecting public health and addressing addiction and drug use across our state.

Since the December, 2009 passage of the Consolidated Appropriations Act of 2010, Congress has allowed federal funding to be used for syringe exchange unless local health authorities or local law enforcement authorities deem a program site to be inappropriate. New York has already benefited from this flexibility, allowing \$1,722,733 of HIV prevention funding from the Centers for Disease Control and Prevention allocated to programs targeting people who inject drugs to be used to support syringe access. In addition, two SAMHSA-funded substance abuse treatment outreach programs in New York (one on Long Island and one in New York City) have received permission to use a portion of their grants to support syringe access. Several other states, including California, Connecticut, New Jersey, New Mexico, Oregon, Vermont, and Washington, have also opted to direct a portion of their federal funds to syringe exchange under the current Congressional policy.

These programs will be jeopardized if Congress adopts policy riders for the remainder of the FY 2011 Appropriations cycle contained in the version of H.R. 1 passed by the House of Representatives. Language in the House FY 2011 Continuing Resolution would impose a complete ban on the use of federal funding for syringe exchange (section 1847 on p. 304). Furthermore, H.R. 1 would restore a parallel restriction on use of local Washington DC tax funds for syringe exchange (section 1591 on p. 243), which Congress had removed in 2007.

New York State currently has 19 syringe exchange programs operating at over 50 sites under authorization by the state Health Commissioner. These programs collectively provide 3 million sterile syringes annually, along with HIV and hepatitis prevention and testing and linkage to primary care and drug treatment. Syringe exchange programs in New York have made over 175,000 referrals to detoxification and substance abuse treatment programs, health care services, HIV counseling and testing, and social services. New York's syringe access programs represent a national model and a major success story in the fight against HIV/AIDS: the proportion of new diagnoses in New York State attributable to injection drug use has decreased from 52% of new AIDS cases in 1992 to 5.4% of new HIV cases in 2008.

HAMS Harm Reduction Network
Harlem United
Harm Reduction Coalition
Health People
Hepatitis C Mentor and Support Group
Hispanic AIDS Forum
Housing Works
Human Services Council
Iris House
Lambda Legal
Latino Commission on AIDS
Legal Action Center
Long Island Health Access Monitoring Program (LIHAMP)
Long Island Minority AIDS Coalition
Lower East Side Harm Reduction Center
Nassau Inmate Advocacy Group
National Advocates for Pregnant Women
New York Association of Alcoholism and Substance Abuse Providers
New York Harm Reduction Educators (NYHRE)
New York State Psychological Association
NYS Council for Community Behavioral Healthcare
NYU Medical Center Midtown Manhattan Hepatitis C Support Group
Perceptions for People with Disabilities
Peter Cicchino Youth Project
Phoenix House
Planned Parenthood of New York City
Prostitutes of New York (PONY)
Positive Health Project
Praxis Housing Initiatives
Public Health Solutions
Safe Horizon
St. Ann's Corner of Harm Reduction
Sex Workers Outreach Project New York City
Southern Tier AIDS Program
Status C Unknown
Supportive Housing Network of New York
SWAN Project of SUNY Downstate College of Medicine
The Bridge
The Space at Tompkins
Treatment Action Group
Turning Point
UHAP/Upstate New York Hepatitis C Awareness Project
VillageCare
Voices of Community Activists & Leaders (VOCAL-NY)
Washington Heights CORNER Project



AIDS COMMUNITY RESEARCH INITIATIVE OF AMERICA

TESTIMONY OF DANIEL TIETZ
Executive Director

New York City Council Committee on Health
Oversight Hearing on HIV/AIDS-Hepatitis Co-Infection:
Education, Prevention and Treatment
April 11, 2011

Thirty years into the HIV epidemic many service providers are accustomed to discussing HIV prevention, implementing behavioral counseling, and offering referrals to clients. However, they are less familiar with providing prevention, treatment, and care messages to those with or at-risk for hepatitis C virus (HCV), and much less prepared to deal with HIV/HCV co-infection.

UNAIDS estimates that 150-200 million people are living with HIV world-wide. In the U.S., approximately four million people have been diagnosed with HCV, and the National Health and Nutrition Examinations Study (NHANES III) estimates one million more remain undiagnosed. Of this number, about 2.7 million people have a chronic HCV infection, making HCV the most common blood-borne infection in the country. An estimated 8,000-10,000 people die each year from HCV-related complications, and this number is expected to grow to 30,000 by 2015. Without effective prevention measures or the development of a vaccine, new infections are expected to continue at a rate of 25,000 per year. Currently, people aged 40-59 have the highest prevalence of HCV, and in this age group African-American men have the highest infection rate (9.8%). Among injection drug users (IDUs), infection rates range from 60-90%, with most users becoming infected within five years of beginning to inject. And most people with chronic hepatitis C are not aware of their infection.

About one-quarter of people with HIV in the U.S. also have HCV. Studies indicate that 80-90% of active or former substance users with HIV are co-infected with HCV, and injection drug use continues to play a significant role in the transmission of blood-borne diseases such as HCV and HIV. As needle exchange programs have improved the availability of clean needles, risky sexual behavior is emerging as a more common means of transmission. The incidence of HCV among men who have sex with men is on the increase, especially among men with HIV who engage in sexual activity with other HIV-positive men, often ignoring that they are also at risk for HCV and other STIs.

In 2003, the NYS Department of Health AIDS Institute received a three-year grant from the CDC to develop and evaluate comprehensive curricula for providers in several settings: substance use treatment programs, STD clinics, criminal justice settings, and HIV prevention and treatment programs throughout the U.S. This project was a collaborative effort with the NYS Department of Health, The NYS Office of Alcoholism and Substance Abuse Services (OASAS), AIDS Community Research Initiative of America (ACRIA), and the NYC Department of Health and Mental Hygiene. ACRIA was responsible for developing the curriculum that was approved by the CDC and for implementing 70% of the capacity-

medical care, but not everyone needs HCV treatment. Not everyone has a successful response to treatment, but we know that those with HCV type 2 or 3, those with lower a lower HCV viral load, a healthier liver, younger than 40, without HIV, and those who are white fare better.

At present, there are limited treatment options and all have side effects severe enough to require the patient to stop treatment before a sustained virologic response, which is the closest we can come to a cure, is achieved. These include fatigue, joint pain, muscle pain, nausea, headaches, weight loss, hair loss, low white blood cell count, rapid heartbeat, irritability, depression, and suicidal thoughts. In clinical trials of interferon and ribavirin, 10-20% of participants dropped out due to side effects or adverse events. And even among those who complete a lengthy and difficult course of treatment, most studies suggest not more than 40% with HCV genotype 1 achieve success in the form a sustained virologic response and maybe twice that rate for those with genotype 2 or 3.

More research and clinical trials are needed to provide more treatment options to people with HCV and to those who are co-infected. ACRIA is working on such studies in collaboration with industry and some may offer hope of significant improvements in sustained virologic response. But for the present time, and possibly even with treatments that are being studied now, HCV treatment often comes with serious side effects that require intensive and ongoing support. Patients must receive education on both the need for and problems with current treatment. More than almost any other disease, HCV requires intensive patient education and a support structure that includes doctors, nurses, counselors, case managers, educators, support groups, friends, and family. Without this structure in place, many people will not be able to complete the treatment course, dramatically lowering its benefit. Add to this the fact that many people are dealing with two life-threatening infections – HIV and HCV – and it becomes clear that much more than a prescription is needed.

Recommendations

With over 15 years of experience in HCV education, we urge the following:

1. Education, Training, and Capacity Building

- i. Comprehensive Trainings and Materials: These should cover all aspects of viral hepatitis (A, B, and C), including the unique psychosocial needs of persons at highest risk for or living with viral hepatitis.
- ii. Training designs that are flexible and modular: Modules need to be tailored for use in different settings and tailored to different time allotments and audiences.
- iii. Content tailored for special settings: Trainings should address the unique needs of staff at STI clinics, HIV prevention and care settings, drug treatment programs, community health centers, and those who work in criminal justice.
- iv. Focus on integration: We must address specific issues and obstacles to fully integrating counseling about viral hepatitis into the above settings.
- v. Skills-based design: Opportunities must be available for providers to develop their skills in providing client-centered counseling regarding viral hepatitis.
- vi. Client education and health literacy: Workshops must be offered to people with HIV, focusing on hepatitis basics, coinfection, lab and clinical tests, prevention, and treatment options.

2. Supportive Services

**Testimony before
The New York City Council
Committee on Health
HIV/AIDS-Hepatitis Co-Infection: Education,
Prevention and Treatment**

Thomas S. Morino, PA-C
Director of Clinic Operations & Administrator for Hepatitis C Clinic

Kimberleigh J. Smith, MPA
Senior Director for State & Local Policy

On behalf of:
Harlem United Community AIDS Center



April 11, 2011

- Finally, co-infection has a disproportionate impact on certain communities, including those in prison and jail and communities of color.¹ Co-infection presents yet another assault on communities of color citywide.

Our experience serving co-infected clients has led us to develop a medical home model of care coordination, support and treatment. This “one stop” shop, led by our Nurse Practitioner HCV coordinator, provides a continuum of supportive services that meet the complex needs of the co-infected and improve retention in care, offered in the medical clinic. The medical home model also leads to improved outcomes by managing chronic illness, reducing medical errors, and lowering hospitalization rates.

Our services include: Healthcare, including two primary medical clinics with co-located behavioral health services (funded by SAMHSA), buprenorphine treatment, adult day health care, dental services, case management, psychiatry, nutrition, syringe access, and mental health services; HIV/HCV/STI prevention, including outreach, peer training, community education and behavioral interventions for PLWHA, MSM, women at high risk, drug users, and immigrants; Testing for HIV, HCV, and STIs with linkage to care and patient navigation services; Integrated harm reduction, including a syringe access program and integrated syringe exchange and testing services through FROST'D, an affiliate organization; and Supportive housing for PLWHA. HU currently provides HIV- and HCV-related medical care, treatment, and supportive services at our primary care facilities.

City government can play a role in reducing the likelihood of co-infection and the impact of co-infection on the people we serve. With better medications in the pipeline, we need to begin building the outreach, education and support needed to help all co-infected persons make informed care and treatment decisions. HIV and harm reduction programs already have much of this infrastructure in place, but we need public health policies and funding support to build the capacity of these organizations to more effectively engage people who are at risk for co-infection and link them to medical care. Over the last thirty years we've developed the infrastructure to provide a safety net for people living with HIV, so they can thrive. By expanding that net, we can do a much better job of meeting the needs of HCV-infected people citywide.

In addition to helping people learn their HCV status and understand their treatment options, we need provider education and support to increase the ranks of culturally competent and sensitive medical providers, ensuring high quality specialty care in medically underserved communities that are confronted with the brunt of both HIV and Hepatitis C.

As I've mentioned, Harlem United provides a range of services for co-infected individuals. But we could do more with specially trained peer educators, health educators and patient navigators to ensure successful care coordination between specialists in a way that is comforting and accessible to our consumers.

Thank you for your time and attention.

¹ <http://www.cdc.gov/idu>