CITY COUNCIL
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TRANSCRIPT OF THE MINUTES

of the

COMMITTEE ON HEALTH

jointly with the

COMMITTEE ON HOSPITALS

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HELD AT: Council Chambers - City Hall

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Chair, Committee on Health

Carlina Rivera
Chair, Committee on Hospitals

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PEDRO LUGO: This is the sound check for the Committee on Hospitals join with Health. Today's date is December 9, 2019, located in the Council Chambers. Recording done by Pedro Lugo.

CHAIRPERSON LEVINE: Good morning, everybody. I am Mark Levine, chair of the City Council's Health Committee, pleased to be joined by our cochair this hearing, Carlina Rivera, chair of the Hospitals Committee. I want to start by acknowledging we have Council Member Danny Dromm who, one of the sponsors of our legislation today, who we'll be hearing from momentarily, as well as fellow Health Committee member, Bob Holden, waving there from the wings. Today we'll be discussing the city's efforts to prevent, address, and ultimately eliminate HIV and hepatitis. Hepatitis is an inflammation of the liver caused by a virus and can lead to fibrosis, cirrhosis, or liver cancer. HIV is a virus that is spread through certain bodily fluids and attacks the body's immune system. Both can be deadly if let untreated, and yet both are preventable. Despite available treatments, and in some cases cures, for these infections, we continue to see new diagnosis every year. However, rates of diagnosis are down, in

large part as a result of the great work accountability DOHMH, and in particular I want to acknowledge Deputy Commissioner Dr. Demetre Daskalakis, who we'll be hearing from shortly, who has been a global leader in this fight. I'm extremely proud of our city's efforts to eliminate and address both HIV and hepatitis and the amazing results we have seen thus fair, such as the achievement of the ending epidemic 90-90-90 goal. While we have undeniably achieved great success in our fight, there are still important steps we must accomplish in order to see an end to both HIV and hepatitis. Although there were declines in new HIV diagnosis among men and women, residents of all boroughs and nearly all age and racial groups, there were still increases in diagnosis among certain populations, including those who are transgender, people aged 50 to 59, and men who report both having sex with men and a history of injection drug use. In 2018 black men had a rate of new HIV diagnosis of 100.8 per 100,000 people, which was 1.5 times higher than the rate among Latinx men, over three times higher than the rate among multiracial men, and over five times higher than the rates among white, Asian,

and Pacific Islander, as well as Native American men. Rates among black women were also disproportionately high, with black women having a diagnosis rate 3.2 times higher than the rate among Latinx women and over 11 times higher than the rates among white, Asian, and Pacific Islander and Native American women. Of those living with HIV and individuals who are black are more likely to die sooner after receiving an HIV diagnosis than their peers. Inequities also persist when looking at the rate of PrEP, PEP awareness among New Yorkers. According to the 2008 Community Health Survey, 80% of Asian respondents and 72% of Hispanic respondents had never heard of PrEP, compared to 60% of white and 57% of black respondents. Although the death rate among those living with HIV has decreased greatly, 28% of those living with HIV died of HIV-related causes in 2017. In order to better understand these inequities, we'll hear Introduction number 1808, which I'm extremely proud to sponsor, a Local Law in relationship to examining the causes and conditions surrounding HIV/AIDS-related deaths in New York City. The proposed legislation would require DOHMH to conduct a survey of all HIV/AIDS-related deaths in

the city between 2017 and 2019 to assess the causes and circumstances that led to each death. The goal of this legislation is to understand where existing gaps in HIV/AIDS services exist and how the city can address those gaps. I am very much looking forward to our discussions today, and I will now turn it over to my cochair, Carlina Rivera.

CHAIRPERSON RIVERA: Good morning, everyone. I am Council Member Carlina Rivera, chair of the Hospitals Committee. Today we are focusing on the prevention and treatment of hepatitis and HIV in New York City. It's estimated that 230,000 people in New York City have chronic hepatitis B and an additional 116,000 have chronic hepatitis C. According to DOHMH data, hepatitis B disproportionately impacts individuals living in Sunset Park East, Flushing, and Queensboro Hill, while hepatitis C is extremely prevalent on Riker's Island. Despite hepatitis C being curable, people who are Latino or black are more likely to die from hepatitis C than others. In fact, the rate of treatment initiation among people newly reported with a positive hepatitis C test has been declining since 2015, with only 30% of people reporting that they

have initiated treatment in 2018. Only 50% of people reported with chronic hepatitis C in 2015 had started treatment by the end of 2018. Inequities also persist in the rate of treatment among those who both hepatitis C and HIV. People living with HIV who are black or Latino living in high-poverty areas and/or with no history of incarceration were less likely than their counterparts to receive treatment for hepatitis C. Inequities also persist amongst the rate of hepatitis B infection, specifically among people who gave birth in 2018, which disproportionately impacts people born outside the United States, mainly individuals who are Asian or Pacific Islanders and/or who were born in China. While I look forward to hearing about all the important initiatives DOHMH has undertaken to help New Yorkers living with hepatitis and HIV, as well as those who are at risk of contracting one or both viruses, I also look forward to hearing from Health and Hospitals. H&H remains the largest provider of healthcare to New Yorkers who are uninsured and they remain committed to providing care to individuals regardless of their ability to pay. H&H serves our most vulnerable New Yorkers. Today I plan to discuss how H&H works to address

hepatitis and HIV here in New York City, their protocols for treating patients with or at risk of getting both viruses, and their roll in addressing both in the city at large. For example, we know H&H serves a large immigrant population. Although people born in the United States and its territories made up 63.9% of new HIV diagnoses, these born, those born in sub regions of Africa had by far the highest rate of HIV. I look forward to hearing from H&H today about how they are meeting the needs of this community, among others, and what more we can do to ensure that we end viral hepatitis and HIV in New York City for good. And with that I want to turn it over to Council Member Danny Dromm so he can read his statement.

COUNCIL MEMBER DROMM: Thank you very much. First off, let me express my thanks to Chairs Rivera and Levine for holding this hearing. The council and the speaker, Corey Johnson, has redoubled its commitment to improving the lives of individuals living with HIV, including tackling the issue of stigma. This and other challenges to ending the epidemic have been closely tied to societal discrimination against LGBTQ+ individuals. Sadly,

such discrimination continues to govern how the federal Food and Drug Administration regulates blood donations. The FDA continues to perpetuate unscientific myths, specifically about gay men. In 2010 this council passed Resolution 80, which called on the FDA to end its lifetime ban on donations from any man who ever had sex with another man. In 2015 the FDA did relax its ban. Now potential donors must wait one year before becoming eligible. Since so many gay and bisexual men are, of course, sexually active, this limitation effectively means countless pints of lifesaving blood are being rejected. It is worth noting that the lifetime prohibition remains for any individual of any gender who has ever accepted money or drugs for sex. Resolution 150 highlights this unjust situation, where prejudice and bigotry seem to have overcome well-researched evidence. Countless scientists and expert organizations have questioned this arbitrary restriction. The FDA must follow their calls to end the ban and increase the amount of available blood. Thank you very much.

CHAIRPERSON RIVERA: With that, we'll have Committee Counsel swear you in.

COUNSEL: And this is for anyone who plans to testify or answer questions. Please raise your right hand. Do you affirm to tell the truth, the whole truth, and nothing but the truth in your testimony before this committee and to respond honestly to council member questions? You can begin. Good morning, Chairs Levine and Rivera and members of the committees. I'm Dr. Demetre Daskalakis, deputy commissioner for the division of Disease Control at the New York City Department of Health and Mental Hygiene. I'm joined by my colleagues from New York City Health and Hospitals, Dr. Nichola Davis, senior assistant vice president for Chronic Disease and Prevention, and Eunice Casey, senior director of HIV Services. On behalf of Commissioner Barbeau I want to thank you for the opportunity to testify today on the health department's work to end the epidemics of HIV and viral hepatitis, and for the City Council's continued partnership in this work. The health department coordinates New York City's response to the HIV epidemic, including HIV testing initiatives, prevention, care, and treatment programming, surveillance, training and technical assistance, administration of federal housing programs, and

community engagement. We are also responsible for viral hepatitis programming, including prevention, surveillance, and outreach activities. The health department and Health and Hospitals collaborate closely in this work. Last week the health department announced that the, that New York City has become the first fast-track city in the United States to achieve the UNAIDS 90-90-90 targets - 90% of people with HIV know their status, 90% of people diagnosed with HIV are on treatment, and 90% of people on treatment are virally suppressed. I will share more about this shortly, but first some background on how we got to where we are today. In 2015 Mayor de Blasio announced the New York City Ending the Epidemic plan, a 23 million dollar annual investment to end the HIV epidemic in New York City by 2020. It builds upon the 2015 New York State blueprint for Ending the Epidemic recommendations from the New York State ETE task force, a coalition on which I served alongside government officials, providers, and community members from across the state. The New York City ETE plan is a four-part strategy - increased access to prevention services, including pre- and post-exposure prophylaxis, also

known as PrEP and PEP, promote innovative optimal treatment for HIV, enhance methods for tracing HIV transmission, and advance sexual health equity for all New Yorkers by promoting comprehensive affirming sexual health care and support, supporting community-driving initiatives focused on people disproportionately affected by HIV. Driving this work is a commitment to dismantle the underlying racism, homophobia, trans phobia, and other identity-based stigmas that lead to health inequities. The New York State and New York City plans have become national and international models for ending the HIV epidemic, including the recently announced federal plan. In 2016 Mayor de Blasio signed on to the Fast-Track Cities initiative, a global partnership of over 300 municipalities around the world working to achieve that UNAIDS 90-90-90 goal. Last week during our World AIDS event, Commissioner Barbeau announced as of 2018 in New York City 93% of people with HIV have been diagnosed, 90% of people diagnosed are on treatment, and 92% of people on treatment are virally suppressed. Not only did we surpass the 90-90-90 goals to achieve 93-90-92, we did it two years early and are the first Fast-Track City in the US to do so.

And that's not all. The annual numbers of New Yorkers newly diagnosed with HIV fell below 2000 for the first time since annual HIV reporting began in 2001. According to our 2018 HIV surveillance annual report, 1917 people were newly diagnosed with HIV in New York City in 2018, down 11% from 2017 and 67% from 2001. These data illustrate the incredible progress we have made over the last several years. Once known for being the epicenter of the HIV epidemic in the US, New York City is now leading the country in ending the epidemic. And none of this would have been possible without the support and investment of local and state government. Speaker Johnson and City Council's unwavering support have been critical to our success. It has allowed us to design and implement forward-thinking approaches to ending the epidemic that have put New York City at the cutting edge of public health. A key element of the New York City ETE plan is ensuring the widespread availability of comprehensive HIV prevention and treatment services. This begins in the health department's eight sexual health clinics, which offer comprehensive, affirming sexual health care regardless of immigration status, insurance coverage,

or ability to pay. Following facility upgrades and service enhancements, all eight clinics now offer low- to no-cost state-of-the-art services, including STI and HIV testing, emergency PEP, or post-exposure prophylaxis, PrEP initiation, and navigation and jumpstART, the immediate initiation of HIV treatment with navigation to longer-term care. Recognizing that good sexual health is not just about preventing and treating STIs, the clinics also provide emergency contraception with longer-term options available, such as pills, patches, rings, and injectables. We do cervical cancer screening, Narcan kits, and sterile syringes, short-term counseling services and referrals for continued care, screening and referrals for alcohol and drug use treatment, and assistance in applying for insurance and social services. This summer we launched the Quickie Lab at Chelsea Express, a cutting-edge laboratory system that tests for Chlamydia and gonorrhea within hours instead of days. This means less stressful wait time, quicker treatment initiation, and reduced risk of disease transmission, and we have seen a record number of patients since the launch. Our partners at Health and Hospitals offer comprehensive, compassionate HIV

and AIDS care for New Yorkers, including confidential, convenient HIV screening and personalized care and treatment at their hospital-based and community-based federally qualified health center HIV clinics. As part of the city's commitment to ending the HIV epidemic, Health and Hospitals has been expanding PEP, PrEP, and other HIV prevention services, including an innovative program to integrate PrEP access into its primary care and women's health clinics. Building a sustainable HIV prevention and care model requires the active participation of providers throughout New York City. To this end, the health department created the PlaySure Network, a network of HIV testing sites, community-based organizations, and clinics, including Health and Hospitals' clinics, that promote patient-specific approaches to sexual health and HIV prevention, provide PrEP and PEP, and link people who test positive for HIV to care. The PlaySure Network currently has contracts with over 40 organizations across all five boroughs. Our PrEP for Adolescents initiative supports four clinical sites, one of which is at Health and Hospitals' Gotham Health East New York, engaging 13- to 24-year-olds in biomedical HIV

prevention services, including screening and education, PrEP and PEP clinical services, and linkage and support services. To more effectively serve young people, the clinics offer co-located services, flexible appointment schedules, and personalized communication with PrEP navigators, including by text messages. We also support four PEP centers of excellence, brick and mortar sites, including Health and Hospitals' Elmhurst, utilizing an urgent care model to ensure timely initiation of PEP and patient navigation and support services. The New York City PEP hotline, available 24/7, links people who may have been exposed to HIV to these and other sites with expertise in PEP. Delivery of HIV prevention services should be standard of care for preventive medicine and other routine medical visits. Our highly trained, full-time PrEP and PEP detailing teams conduct one-on-one educational visits for the providers, with the latest cycle focusing on women's healthcare providers. So far our detailing campaigns have reached over 5100 providers at more than 2900 clinical sites. Our outreach also includes training and technical assistance to clinical and nonclinical providers. Most recently, we've been educating

providers and the public on the importance of immediate initiation of anti-retroviral therapy on the same day as an HIV diagnosis or first clinic visit, as we have been doing for years now in our sexual health clinics. Much of our programming is focused on specific populations that are disproportionately affected by HIV, such as black and Latino men who have sex with men. While there was nearly a 20% decline in new HIV diagnoses among MSM from 2017 to 2018, of all men newly diagnosed with HIV in New York City in 2018 67% were MSM and more than three-quarters, 78%, of newly diagnosed MSM were black or Latino. Our online HIV home test giveaway uses dating apps and social media to reach MSM and transgender and gender nonconforming people who have sex with men. We distributed 12,000 tests and 16% of participants reported never having been tested previously. The incredible success of this program prompted the New York State Department of Health to adapt it to other parts of the state. Our Project Thrive initiative involves community-based organizations providing HIV and STI testing and status-neutral care navigation to black and Latino gay and bisexual men and other MSM of color in

Brooklyn. And New York City is one of four jurisdictions awarded a CDC demonstration project grant to use molecular HIV surveillance to map possible transmission networks among Latino MSM to implement high-impact HIV prevention services. We also have expanded services to reach individuals who may otherwise not seek care. Our Recharge program is an HIV status-neutral and sex-positive harm reduction program focused on MSM who use crystal methamphetamine. It features twice-weekly drop-in groups facilitated by a peer-support worker and licensed social worker and a range of individualized services, including health education, individual and group counseling, and medical and psychiatric visits. Earlier this year we launched an enhanced home-based care initiative, which brings our services directly to people who are not comfortable engaging in a traditional care setting. We've created a virtual sexual health clinic whereby nurse practitioners link through telemedicine and our disease-intervention specialists make visits in the community to provide HIV and STI testing, immediate PrEP initiation, immediate initiation of anti-retroviral treatment for people diagnosed with HIV and linkage to continued

care with local providers. We also recognize the essential role in grassroots leadership in HIV prevention efforts. Earlier this year we announced funding for six small community-based organizations as part of our first-ever micro grant initiative, which supports the design and implementation of projects that build resilience, promote sexual health as the essential ingredient in HIV prevention, and develop community leaders. We also continue to offer capacity-building technical assistance to four transgender- and gender nonconforming-led organizations. New York City has been a leader in changing the conversation around HIV to reduce stigma, encouraging HIV testing, prophylaxis use, and retention in HIV care. For example, we were the first US jurisdiction to sign onto Undetectable is Equal to Untransmittable, or U=U. The evidence-based finding that people with HIV who are treatment and maintain an undetectable viral load cannot transmit HIV through sex. Now, even the federal government has made U=U a central component of its ending the HIV epidemic plans. Another key message is status neutrality. In 2016 we released the New York City HIV status-neutral prevention and treatment cycle

that reflects that HIV care does not end with the first undetectable viral load. High-quality care empowers people with HIV to get treatment and remain engaged in care. Similarly, high-quality prevention services for people at risk of HIV help keep them negative. A status-neutral approach means that whether you're HIV-negative or HIV-positive there are options to keep you and your partners healthy. These concepts have transformed perceptions about HIV among people living with HIV and in their communities. These and other messages are at the foundation of our sexual health media campaigns. New York City has become internationally recognized for using dynamic sex-positive messages and images to educate the public, help reduce stigma, and promote our core HIV prevention, care, and treatment messaging. Our Bare it All campaign, first released in 2017, encourages LGBTQ New Yorkers to talk to their doctors about everything that affects their health. It empowers them to find a new doctor if they cannot have these conversations. Living Sure, launched in March 2018, encourages cis gender and transgender women to consider PrEP as part of their sexual health plan. Our 2018 Listos campaign encourages Latinos of all

genders and sexual orientations to consider PrEP and was the first campaign that we created in Spanish from the start, and our most recent campaign, Made Equal, released in June during Pride promotes U=U and is designed to reduce HIV-related stigma, celebrate healthy sexuality and sexual pleasure, and redefine what it means to live with HIV. Like so much of what we do, these marketing campaigns were developed with the direct input of the community. These campaigns encapsulate how we approach our work, science-based, focused on empowerment and sex positivity and not on stigma, and tailored to resonate with the people that we need to reach. I'm incredibly proud of the ground-breaking work we have done and we have truly served as a model for the nation and the world. We must remain vigilant in our HIV prevention and treatment efforts to ensure that we maintain the ground we have won, conquer new challenges, and reach our ultimate goal of ending the HIV epidemic in New York City once and for all. Now, I'll turn to the health department's comprehensive viral hepatitis work. All New Yorkers living with viral hepatitis should know their diagnosis and receiving care to manage or cure their disease. In New York City there

are 230,000 people estimated to be infected with hepatitis B and 116,000 people estimated to be infected with hepatitis C, diseases that lead to cancer and premature death, but are preventable, treatable, and in the case of hepatitis C curable. As reflected in our 2018 viral hepatitis annual report, while the number of reported chronic hep B and C cases has been steadily declining in recent years, there were 6075 and 4682 newly reported cases of hep B and C, respectively. Hepatitis B and C continue to disproportionately affect marginalized populations, including people who use drugs, people with a history of incarceration, people living in high or very high poverty neighborhoods, and immigrants. We have at our disposal tools to end these epidemics. Hepatitis B can be prevented through vaccination and people who are chronically infected can be treated to prevent liver disease and cancer. Hepatitis C can be prevented through harm reduction and substance use treatment and can be cured. Despite these effective medical interventions, many people at risk for or living with hep B or C in New York City are unaware of their risk or their status and are not in clinical care or

prevention services. The health department is a committed partner in national and statewide efforts to eliminate viral hepatitis by 2013. Since 2016 the health department has been a member of the New York City Hepatitis C Elimination initiative, a statewide coalition of providers, advocates, and government representatives. We are also a member of the New York City Hepatitis C Elimination Task Force, which developed a comprehensive elimination plan that was submitted to the governor's office. Last year the health department developed a New York City-specific strategic plan that defines priorities and goals to address viral hepatitis to guide activities for the next five years. This plan has three goals, which build on our existing clinical and community-based work - identifying and share information about trends in viral hepatitis infections to promote citywide improvements in health care access and treatment, support healthcare organizations in eliminating hepatitis C and managing hepatitis B, and substantially reduce new viral hepatitis infections in New York City. The health department provides a wide range of viral hepatitis services. This includes promoting the importance of hepatitis A, B,

and C prevention and screening to people at high risk of acquiring these infections, including people who use drugs, people who have sexual partners with hepatitis A, B, or C, MSM, and children born to mothers with hepatitis B or C. Our sexual health and immunization clinics provide hepatitis A and B vaccinations, including to people who are under-insured or uninsured. We provide hep B and C navigation services for people who are out of care, focusing on pregnant and postpartum persons, people living with HIV, people who use drugs, young people with new infection, and other priority populations. We have intensive case management for pregnant people with hepatitis B to help ensure infants who are exposed to the virus receive prophylaxis. We also examine surveillance data and perform case investigations to better understand the epidemiology of hepatitis B and C epidemics in New York City, prevent new infections, and promote linkage to care and treatment. Health and Hospitals is an important source of hepatitis B and C care. Patients diagnosed with hepatitis C are supported through cure. Last year over 1000 individuals were cured of hepatitis C at Health and Hospitals facilities. An essential

component of our viral hepatitis programming is the community navigation contracts we manage for hospitals, health centers, community-based programs serving immigrant communities and syringe service programs. The City Council support is instrumental in this work. In 2014 the health department established the Viral Hepatitis Initiative with funding from the council. This initiative provides funding for community health organizations to hire and train hepatitis C and hepatitis B navigators who form the core of the Check Hep B, Check Hep C, and Hep C peer navigation programs. Since 2014 an estimated 13,630 people at risk for or living with hepatitis B or C received navigation services. And 5983 people recommended hepatitis B or C care and treatment through the Viral Hepatitis Initiative. The 14 syringe service programs provide vaccination, testing, and care coordination, oversee prevention and harm reduction education, distribution of sterile syringes and other drug use equipment to prevent the transmission of blood-borne diseases, and access to buprenorphine treatment. In 2018,18,274 people participated in syringe service programs and over four and a half million syringes were distributed.

Since 2016 we have collaborated with the Empire Liver Foundation to deliver the Hepatitis Clinical Training Program, which aims to increase the number of clinical providers who screen, diagnosis, manage, and treat hepatitis B and C in accordance with national guidelines. Nearly 2000 providers have been trained as part of this program. Other clinical quality improvement projects include collaborating with health centers to promote hepatitis C screening and treatment and generating facility-specific dashboards for 40 New York City hospitals, which are shared with hospital leadership and provide information regarding the number of their patients with hepatitis C and the number who have started treatment. We also organized Hep Free NYC, a network of over 200 community organizations working together to build capacity to prevent, mange, and treat hepatitis. One of our most exciting projects is our micro elimination to eliminate hepatitis C among people living with HIV I New York City. This work began with Project Succeed, a three-year, federally funded intervention that aims to improve health outcome and reduce ethnic and racial disparities among people with co-infections through three main interventions - practice

transformation, education and training, and case investigation and linkage to care. The health department delivered technical assistance to healthcare facilities with the highest number of patients with hepatitis C and HIV co-infection and provided grants to nine facilities to improve their hepatitis C screening and treatment practices. In addition, health department patient navigators reached out to nearly 400 individuals with hepatitis C and HIV co-infection to provide linkage to care services. As of the end of 2017 62.5% of the estimated 8988 people in New York City diagnosed with hep C and HIV co-infection had initiated treatment for hepatitis C. Though this federal funding is ending, it has helped to put the structures in place to continue to achieve hepatitis C elimination among people living with HIV. Intro 1808 2019, regarding the bills being heard today Intro 1808 would require the health department to conduct a study of all HIV/AIDS-related deaths in the city between 2017 and 2019 to assess the causes and circumstances that lead to each death. This bill recognizes the fundamental concept that every HIV-related death is preventable. We made incredible strides in reducing HIV-related

deaths. This has been achieved through early detection, linkage to care, and efforts to maintain viral suppression. Every program I just detailed plays a role in reducing HIV-related deaths and we're happy to talk to you about how we can work together to bring the number of HIV-related deaths down to zero. Resolution 150 - while the administration does not typically comment on resolutions, Resolution 150, which calls on the US Food and Drug Administration, the FDA, to remove blood donation restrictions based on sexual orientation is particularly relevant to the health department's work. The FDA's current exclusion of MSM who report having sex in the last 12 months excludes many low-risk men who would be excellent candidates for blood donation. This stigmatizes gay and bisexual men as vectors of HIV transmission, suggesting that all sex between men is high risk, regardless of frequency, number of partners, and proven protective measures, including condoms and HIV prophylaxis, such as PrEP and PEP. The health department has been a national voice to lead efforts to push the FDA to change its stigma-based exclusionary policy. In 2016 the health department called on the FDA to change its blood

donor deferral policy and replace it with an evidence-based three-step screening process that does not exclude potential donors based on sexual orientation or gender of their sex partners. This process includes a behavioral risk screening for every potential donor, point-of-care rapid have testing for donors who report sexual risk-taking behavior, and continued testing of donated blood per FDA's current recommendation. The screening process is an opportunity to increase HIV testing rates and link more people to care while further improving the safety of the blood supply using science rather than stigma-based exclusions, and would allow thousands, if not hundreds of thousands of gay and bisexual men to once again the lifesaving gift of blood. I have personally been involved in efforts at the federal level to change blood donation rules through participation on the FDA's Blood Equality Medical Advisory Board. We are grateful that the City Council and especially Council Member Dromm are aligned with us in this fight. I wish to thank Chairs Rivera and Levine for holding this hearing today. I'm proud to be your partner in this work and I'm happy to answer any questions.

CHAIRPERSON RIVERA: Thank you so much. You, you've covered a lot of ground, so I do have, I have a lot of questions, but I just want to thank you. I just want to thank you for your commitment to this work and for really trying to run a comprehensive program for New York City. It's a big city and we've come a long way, and I know that we all have people in our lives that we've lost or who are ill and we certainly want to improve those outcomes. So let's start with something fairly general. You mentioned the initiative to end the HIV epidemic in New York City by 2020. How is that going?

DR. DEMETRE DASKALAKIS: Well, so it's going really well. So I think we have achieved a couple of things on the way, including that 90-90-90 milestone, which is so important. Our number of new HIV diagnoses continue to decline, and our incident, or new HIV infections, are also really on a steady decline as well. At the state Ending the Epidemic meeting that happened last week, the person who is the head of the AIDS Institute in New York State presented that there will probably be a change in the target for ending the epidemic in terms of the number

of new infections that we need to achieve by 2020 because of a change in the CDC methodology for estimating those new infections, though I don't have a number for you yet because we have to follow the state's lead to be able to generate our own goal. Based on our behind-the-envelope calculations, based on that goal, we continue to be on target to end the epidemic given the fact that methodologies have changed in measuring.

CHAIRPERSON RIVERA: Over the last year at the federal level here in the council there's been a lot of attention on PrEP and PEP...

DR. DEMETRE DASKALAKIS: Yes.

CHAIRPERSON RIVERA: ...and having, I guess what is a win in terms of accessibility. It's not a perfect system and it's certainly still costing people, I think an unacceptable amount of money to access it. But where can a person get PrEP or PEP in New York City and what about those without insurance?

DR. DEMETRE DASKALAKIS: Great questions. I'll start by saying that we agree with you that the cost of PrEP is potentially prohibitive. I'm going to add something else, that the perception of the cost of PrEP is also prohibitive, so that, that's

another element. And I'll also mention that we submitted federal testimony about the importance of affordable PrEP. So thank you for your leadership on that in that area as well. So for uninsured individuals in New York City, there are several ways that PrEP can be accessed. The good news is that New York State has a program called PrEP Assistance Program. It's loosely based off of the uninsured treatment programs for HIV, so the ADAP program, and so this program provides financial support for individuals to pursue the care that is attached to pre-exposure prophylaxis, so that means HIV testing, STI testing, etc. Individuals are then directed with navigation to use the patient assistance programs that are offered by the company that produces the drug approved for PrEP. The good news also is that the federal government has a new program that we will take advantage of that will provide PrEP to individuals. It's important to mention that the PrEP Assistance Program as well as the patient assistance program is available to individuals regardless of immigration status.

CHAIRPERSON RIVERA: And in the 2018 community health survey 80% of Asian respondents and

72% of Hispanic respondents have never heard of PrEP versus 60% of whites and 57% of black respondents. So what is the agency doing to address this discrepancy in outreach and how are they doing it?

DR. DEMETRE DASKALAKIS: Well, we're seeing better and better numbers from the perspective of awareness and it's important to note that among men who have sex with men, specifically of all races, we're seeing a really steady increase in PrEP update. I believe that the number in New York State is about 41,000 people who are on PrEP now. I think the goal is to get to 65,000. Let's be honest, the majority of that number is driven by New York City, not by Rochester. And so we are doing sort of, we are sort of swift in terms of that number. But what we are doing to increase PrEP uptake is really by using our surveillance data to target providers who are taking care of those specific populations. Also, we have launched our programs for PrEP at our sexual health clinics really based on the fact that we are seeing mainly people of color using our programming, and so we're really, by sort of putting the services where people come, there's the educational component but also the access component. Additionally, we have

covered the city in lots of PrEP data and lots of PrEP campaigns. We will continue to do so. We also are trying to make sure that people know how to access HIV as well as LGBTQ sensitive services and programming through our Bare it All campaign, as well as through our Bill of Rights, and I think you actually have a copy of the only jurisdictional Bill of Rights for LGBTQ people for healthcare in the country at your fingertips up there. So the answer is we're going to, we continue to promote both to providers as well as to potential users of PrEP, and then also work hard to sort of address some of the inequities that are inherent in care in New York.

CHAIRPERSON RIVERA: I'm going to ask you about the surveillance data in a second...

DR. DEMETRE DASKALAKIS: Yes.

CHAIRPERSON RIVERA: But what happens when PrEP assistance, PEP assistance runs out?

DR. DEMETRE DASKALAKIS: So the PrEP, at least the PEP, it's the PrEP Assistance Program, PREP AP, it's funded by the state and so that, that's consistent. The issue I think that you're raising is what happens when people hit their cap if they're using...

CHAIRPERSON RIVERA: Yes.

DR. DEMETRE DASKALAKIS: Great, so the current cap for the patient assistance program that is provided by the company that produces the drugs that are approved for PrEP is $7200 a year. So for most people that is enough assistance to be able to, that's, all right, let me rewind. PrEP assistance for folks who have a co-pay $7200 per year. For most people that should be adequate. For individuals that that is not adequate, they should now qualify for the new federal program in terms of being able to sort of, ah, the safe safety net [inaudible]. Additionally, we don't turn people away from our sexual health clinics. We ideally are using our PrEP supply to start people on medicines when it's a new drug, but we also have served as safety nets for people who are actually, have an issue accessing PrEP because of a gap. The patient assistance program for uninsured people as far as I'm aware does not have a cap from the company.

CHAIRPERSON RIVERA: For uninsured?

DR. DEMETRE DASKALAKIS: For uninsured. The $7200 cap is for individuals for the co-pay. We can confirm that, but that's my understanding.

CHAIRPERSON RIVERA: Thank you. So in your testimony you mentioned enhancing methods for tracing HIV transmission, which allows the department to mas possible transmission networks. I know you specifically mentioned the Latino community, but just trying to identify New Yorkers who might be at risk or infected with HIV and link people to care, can you explain how DOHMH does this?

DR. DEMETRE DASKALAKIS: Sure. It's very high tech. So the, when an individual is diagnosed with HIV one of the things that happens as a part of their care is that they get a resistance test. So that's a genetic of their virus to see what drugs the virus is susceptible to. So clinically people use that to decide what medicine someone is going to start. But we get those results through lab reporting sent to our HIV surveillance group and what we're able to do, because we have a bank of, you know, a couple, almost a couple hundred thousand of these resistance tests is that we can look at the genetic information of the virus and create what really are transmission chains so we can see sort of where transmission is happening. What we do then is when we identify a transmission chain we see if there

are people who are in that transmission chain who are living with HIV but who don't have evidence of care. What we then do is our ace team, which is our disease, ah, disease intervention specialist team at the Bureau of HIV, get assigned those individuals to seek them out and bring them back to care. We tend to have a pretty good batting average with that, so about 50% of people who we reach out to through our ace team services in the community actually do return to care.

CHAIRPERSON RODRIGUEZ: Thank you. You said 53%?

DR. DEMETRE DASKALAKIS: About 50%.

CHAIRPERSON RODRIGUEZ: Excellent. OK. So I just want to go to hepatitis. You have some incredible information about hepatitis and what we're trying to do in New York City, and I want to go back to these communities that aren't being reached, and I know that you're trying your best and I'll ask about those methods in a second. But when it comes to hepatitis C, people, it's curable, we know that. Fifty percent of people reported with chronic hepatitis C in 2015 had not started treatment in

2018. What are the barriers to treating a person with hep C and why are there so few cures?

DR. DEMETRE DASKALAKIS: Yeah, I mean, I think that there's, that one of the earlier barriers was the cost of the drug, the drugs. So they tended to be extraordinarily expensive. So I'll just comment that, that I was on the FDA panel that recommended approval of the drug Sovaldi and that was the first of the drugs that really made it easier to treat hepatitis C without interferon, which is an injectable, and in my comments after I voted for approval of the drug my next line and please don't make it exorbitantly expensive, and of course it was made exorbitantly expensive. And so there was a while there that lots of insurance plans were not covering hepatitis C medicines or were covering hepatitis C medicines with sort of complex prior authorization requirements that were off-putting both to patients and to providers. Subsequently, because of the leadership in New York City and New York State we've seen a really significant decrease in the threshold to be able to get people on these medicines. It's still a little bit complicated to navigate, but when people actually do come to care

and they are candidates for hepatitis B or C treatment we're able to access drug now, so really the issue is about making sure people are tested, so there have been some significant and important changes to regulations about testing, so baby boomers are, are supported to get tested and I think that has resulted in a lot of diagnoses made. So our challenges really end up being about knowledge of hepatitis C status and then sort of areas that sort of revolve around linkage to care, which is why with the amazingly generous support of council we put so much effort into navigation because that's where we think the problem is. So we have people who are like out there getting diagnosed and all of a sudden have to sort of navigate a system that's very complex and so assisting them in the navigation is really what we think is a strategy because when we bring them to facilities such as our H&H colleagues, you know, we actually see that they get into care and they're cured.

CHAIRPERSON RIVERA: Thank you. I'm going to hold some of my questions, and so I'm going to turn it over to Chair Levine to ask, and just thank you so much.

DR. DEMETRE DASKALAKIS: No, thank you.

CHAIRPERSON LEVINE: Thank you, Chair Rivera. I want to start by acknowledging just the incredible success story that New York City's response to this epidemic has been. We went from being the global epicenter of a very frightening, deadly epidemic to being, I think, the global model in how a city can respond and the, the metrics that we are achieving now are extraordinary. It might not have even been believed 10 years ago, and I really want to acknowledge DOHMH and our public hospitals and you particularly, Commissioner Daskalakis, as being a global leader and a source of a real hope for people around the world who are fighting this. So our questions on the work yet to do here today shouldn't, shouldn't negate the success that we really do have cause to acknowledge. We have seen a remarkable drop in the incidents of HIV among all racial, ethnic, and economic groups, but there are a few areas where the numbers are not moving in the right way, including for New York as a trans experience, for, as I mentioned earlier, men having sex with men who also are intravenous drug users, and curiously also people in a very narrow age band,

those between 50 and 59. Could you explain what those, what's underlying those trends?

DR. DEMETRE DASKALAKIS: So I think we'll start with transgender individuals. So I think part of it has to do with the fact that trans individuals across the country and across the world are over-represented in new HIV diagnoses. I think that we continue to experience a country that is trying to erase transgender individuals from existence and I think that that sort of stigma then is a driver for HIV. I wish I had a more specific answer to that, but I do feel that really when you create an investment where a population is unwelcome or feels unwelcome there are some challenges. I do think that New York is increasingly a better example of ways that individuals are able to access service if they are of a gender nonconforming or transgender experience with Medicaid covering a lot of gender-affirming care and lots of private insurances, you know, covering that care as well I think that areas are becoming more welcoming. We, um, you know, are concerned about sort of the stigma that keeps people away from HIV prevention if they're transgender and so our Bare it All work and our work to identify

facilities that we know are really good transgender care facilities and drive our folks who are reaching out to us to those facilities is sort of an effort to try to acknowledge this, and also in our sexual health clinics when, you know, we noted that we had to do some work to make them more affirming for transgender individuals, so lots of trainings have happened to every level of staff, from the person who welcomes you to the door to the custodian. So we really are trying our best to make the environment better. But I do think that a lot of the transgender story is driven by, by stigma and it's something that we have an ongoing effort to address.

CHAIRPERSON LEVINE: I appreciate that, and I want to talk about the other groups as well.

DR. DEMETRE DASKALAKIS: Yes, please.

CHAIRPERSON LEVINE: Can we pinpoint where exactly we're falling short? Are we disproportionately less likely to get transgender individuals PEP and PrEP? Are we disproportionately less likely to get them a diagnosis or to get them into treatment? Can you pinpoint where along that chain we're really falling short?

DR. DEMETRE DASKALAKIS: Well, I can tell you that from a lot of our PrEP programs we don't have a lot of trans people who are taking us up on PrEP, and we think that there's, and having had lots of conversations with folks in the community we think that there's some misinformation or disinformation about how PrEP interacts with hormones, and so we're working to make that very clear that there's no interaction. So an example is in our Living Sure campaign our ads actually said very clearly that there's no interaction with hormones on purpose, and it didn't sort of specify whether they are hormones for contraception or for sort of gender-related strategies. So I think that we have a little bit of sort of medical mistrust that we have to work against, that's not aided by the fact that there are advertisements on Facebook and Instagram that are telling people that PrEP may be unsafe. So there's, we're working against some challenges.

CHAIRPERSON LEVINE: Is this an organized movement, like the anti-vaxer movement?

DR. DEMETRE DASKALAKIS: It's not an organized movement like the anti-vaxer movement, but there's a, there's, there are some advertisements

that we've actually put an op-ed out about specifically, you know, definitely there's some really, ah, you know, interesting conversations out there regarding a, a lawsuit that's happening, a community versus the company that produces PrEP, but it's not about PrEP. Unfortunately there's been some confounding of that message in social media.

CHAIRPERSON LEVINE: It's just so frustrating...

DR. DEMETRE DASKALAKIS: It is.

CHAIRPERSON LEVINE: ...that misinformation out there. We have to counteract it times 10 or times 100. We've confronted that in the vaccine, ah, challenge and very disappointed here.

DR. DEMETRE DASKALAKIS: Yes, it is a challenge when people are working against you.

CHAIRPERSON LEVINE: Could you comment on any of the unique circumstances faced by MSMs and then also that very specific age group?

DR. DEMETRE DASKALAKIS: Yeah, so I'll start with the age group. So one of the things that we can, so we do believe there is probably transmission in that age group. We also think that testing may be increasing because of changes in the

[long] advising people to test folks who are older, so that could be a piece of what we're seeing, that we have a little bit of a screening bias. But at the same time we think there's transmission. With that said, we know, again, our strategy is that in our, in our outreach when we do our PrEP and PEP detailing it's actually based on surveillance data. So we're visiting providers who have made HIV diagnoses, which means that we're visiting providers who have made the HIV diagnoses in these individuals in that tight age bracket to remind them that older people do in fact have pleasurable sex and should be advised of how to prevent HIV, and also to remind them about testing. In terms of MSM who are also people who inject drugs, we're currently trying to unpack that a bit deeper. I don't have a, a data-driven answer for you yet. We suspect that this is at least partially fueled by opioids and also fueled by crystal methamphetamine. And so we have, you know, a very robust program, the Recharge program, that specifically focuses on methamphetamine because years ago we noticed that there was an increase of methamphetamine use among men who have sex with men, specifically younger men of color, and so, you know, I think that that issue

is out there and that focusing on harm reduction that looks at the opioid issue, but also on crystal meth is critical, and, like I said, Recharge is out there doing the work. I think that there is more work to be done. And another important comment to note is that we, ut-oh, we have, it's a brief line in the testimony, but our sexual health clinics are now distributing syringes and that's really important because the people who are using crystal methamphetamine who are highly sexually active are using our clinics for sexual health services and so by coupling this program close to sexual health services it allows us the opportunity to provide syringes to people who may not go to regular syringe availability programs.

CHAIRPERSON LEVINE: That's great news. The sexual health clinics are such an important resource for New York City, and you mentioned this before, but important to reiterate that people who don't know where else to turn for things like PrEP or PEP always have an open door there. You did say that the emphasis is on people who are uninsured, and that leads me to ask about folks who do have insurance but for whom the full cost is not covered. It seems that

there's a wide variety of covering policies depending on in your insurance plan, and even amongst New York City employees there are different levels of covering. My understanding is that for employees of the police department there's particularly egregiously limited covering for things like PrEP and PEP. Could you comment on the level of unevenness amongst various insurance plans?

DR. DEMETRE DASKALAKIS: So in general that's why PrEP navigation ends up being very important, because individuals who are looking to go on PrEP usually to be navigated to insurance plans that have better pharmacy coverage, and so in general I think your point that there's a broad range of coverage for PrEP is true, whether it's ACA plans or other. So I think appropriate navigation is usually necessary and so individuals who are interested in starting PrEP, if they don't know where to go to figure out like what the best sort of strategy is from the insurance perspective, that's a really good use of our sexual health clinics because our, and in the epidemic navigators are actually trained to sort of troubleshoot those issues. I can't, I will speak in advance for H&H and say I believe that they have

the same kind of services in their facilities to assist people to, to access PrEP.

CHAIRPERSON LEVINE: Like to clarify that?

UNIDENTIFIED: Yes, we do have PrEP navigation services. We have a variety of services. So sometimes we have dedicated navigators who are actually mini grant funded through the Department of Health and with City Council support in some case. And in other cases we use pre-existing services, so like our women's health clinics have financial advisors. Many of our clinics have financial advisors and we make sure that they are aware of how to connect people to PrEP services.

CHAIRPERSON LEVINE: Excellent. By the way, this is clearly a very popular hearing because we're being photographed regularly. That's the strobe light.

DR. DEMETRE DASKALAKIS: I thought it was the alarm. That's good [laughs].

CHAIRPERSON LEVINE: So the number of deaths from HIV a year, it's a little difficult to be absolutely precise, but I think we can say it's about

60 New Yorkers a year for whom the cause of death is attributed to HIV? Do I have that number right?

DR. DEMETRE DASKALAKIS: So you said 60?

CHAIRPERSON LEVINE: Yeah.

DR. DEMETRE DASKALAKIS: It's, the actual, the number is 28% of about, as of 2017, 1700. So it's closer to about whatever a third of that is.

CHAIRPERSON LEVINE: I'm sorry, so that's the number of people whose death is attributed?

DR. DEMETRE DASKALAKIS: Correct.

CHAIRPERSON LEVINE: So you said 20 of 1700, so.

DR. DEMETRE DASKALAKIS: So it's about 30% of...

CHAIRPERSON LEVINE: About, sorry, forgive me, I had it wrong.

DR. DEMETRE DASKALAKIS: Four hundred and change.

CHAIRPERSON LEVINE: Four-hundred and seventy-six. Is that right?

DR. DEMETRE DASKALAKIS: Yeah, about 400 and change, that's correct.

CHAIRPERSON LEVINE: I think you acknowledged earlier that every single death is

unacceptable in that we now have the medicine, the systems, the policies, the resources in place to prevent this from ever happening, and so every death only occurs because there was a failure somewhere along the way. It's important that we understand and learn from every death so that we can prevent this from happening in the future. We have a bill that we are presenting that seeks to collect robust information on every single case so we cannot repeat the mistakes that have led to these tragic deaths up till now. Could you comment on the kind of information that you are gathering on each individual case today and how, if you believe that's different from what we are, would be mandating in this bill.

DR. DEMETRE DASKALAKIS: So we actually provided you all with a manuscript called "Missed Opportunities - Adapting the HIV Care Continuum to Reduce HIV-Related Deaths." It actually was a paper that we published in 2017 with the methodology that we have integrated into our surveillance and planning. This is a opportunity to use our surveillance data to look retrospectively at people who died of HIV, so specifically HIV-related deaths, to see where there are gaps in the continuum. So

I'll remind you that when we look at care of HIV we use our continuum of care as our planning tool to identify where gaps are in care. And so by building a retrospective continuum of care for people who passed away from HIV we're actually able to identify where the gaps occur, and so from the perspective of population-level health we're actually doing this already from the perspective of surveillance. And what we've learned is that, that the gap really is not in care. So we actually see about 82% of individuals who died of HIV, when you look back, had actually touched health care. The problem is what happens when they're in health care and maintaining health care, so you'll see that there's a drop-off of individuals who start anti-retroviral therapy and there's a drop-off in viral suppression for those individuals as well. So what we believe that means is that the social determinants of health that we're very well aware of are actually the barriers to accessing HIV medicines and ultimately viral suppression despite being engaged in care. So that means that individuals who are having housing issues, mental health issues, or who are drug users we think are the folks who are falling between the cracks from

the perspective of starting and staying on medicines. With that said, that actually then dictates to us where our programming needs to be and so when you look at our Ryan White portfolio of work that we do, so much of it focuses on care coordination and keeping people who are coming to care in care, and working with providers to get them on, get individuals on medicines and keep them on medicines. So I think that we would love to have a deeper conversation about the bill, but I think that right now I can say that we're doing the work on the population level and have really identified some really good strategies that are driving the HIV death rate down, and so though the numbers continue to be jarring, because we don't want to see anyone die of HIV in our jurisdiction, the really amazing news is that we have really crossed a couple of important thresholds. So HIV-related deaths are way lower now than other causes of death, really prompting me to remind people that tobacco cessation and getting tested for hepatitis and treated for hepatitis are actually really important, because that's how people are dying. And so we're seeing historic declines in our HIV death rate. So with the work that we're

doing, what we've already put in place, we're actually seeing a freefall in these HIV deaths as well already.

CHAIRPERSON LEVINE: That's amazing. And that's a great moment to pause. I'm going to allow some of my colleagues if they have questions. Before I do, I want to give you a chance to explain what are these...

DR. DEMETRE DASKALAKIS: [laughs]

CHAIRPERSON LEVINE: ...extremely stylish [inaudible]?

DR. DEMETRE DASKALAKIS: So in your head you have the Keith Herring and Mark Jacobs version of the New York City PlaySure kit. So it's a safer sex kit that actually, that is designed around the fact that we have newer technology to prevent HIV and so you'll see that when you open this kit there is this lovely lubricant container, because lubricant is important in, ah, preventing trauma and potentially mechanisms for HIV transmission. When you flip the kit you will see that there is a well where the New York City condom is prominently displayed, and there's a pill box around the side for individuals who are on HIV medicines. They can put their HIV

meds, U=U, so they don't transmit if they're undetectable, and if they're on PrEP, PrEP is safer sex. So it gives them the option of putting their pre-exposure prophylaxis in a kit, throw it in their bag, and go wherever they wish. And also, though, we only have a few left, I wanted to also highlight this is the BloodSure version of the HIV pre-exposure, the PlaySure kit, so a couple of years ago we collaborated with an artist who created a piece called Blood Mirror, which was about the FDA ban on blood donation and so to increase knowledge about this FDA ban we created a bag and a PlaySure kit to remind people that there are still major disparities in blood donation. So we encourage you to use your PlaySure kit as you wish.

CHAIRPERSON LEVINE: All right [inaudible]. I want to acknowledge that we have also been joined by a fellow Health Committee member, Dr. Mathieu Eugene, as well as Hospitals Committee member Francisco Moya. And I do want to ask about hep C, or hepatitis in general. This is a disease which we have solid testing for, which we have a reliable cure for, and for which I think we pretty well understand the social determinants. Therefore, it should be

eliminated. And the World Health Organization, as you know, has established an ambitious but achievable goal for the world, is eliminating this epidemic by 2030. Can you confirm, has New York City signed onto this goal and if so are we on track to achieve.

DR. DEMETRE DASKALAKIS: So we're always precocious and focused on the city and state. So we've signed onto the 2030 goal, but it's a state goal, and we're excited that that also happens to be the WHO goal.

CHAIRPERSON LEVINE: And can you talk to us about our progress towards meeting it?

DR. DEMETRE DASKALAKIS: Yeah, so I think we're, you know, I think we have a couple of really great signs, very similar to HIV. You know, with the beginning of the end of the HIV epidemic was in some ways first signaled by what we saw with people who inject drugs, where we used to have a thousand new diagnoses in 2001 and now we have, I think the number was 12 or somewhere in that magnitude, in this last year. And so in certain populations we're actually seeing that we're moving in the right direction. I think one of the best examples is our micro elimination strategy for people who are living with

HIV and hepatitis C. Over 60% of people who are diagnosed with hepatitis C who are living with HIV have been, are on medicines or have been treated for their hepatitis. So we know we can do it. The reality is that the federal government has very under-resourced hepatitis C and so what we're working on working with is really the generosity of City Council that's provided us, provided us really important funding to do what you need to do with viral hepatitis, which is to identify people who are living with the viral, with viral hepatitis B or C and then navigate them to great services where they can get cured. So it's really about access and care, and so I think we're seeing, we're moving in the right direction. I'm going to be optimistic that we're on target for 2030, but I mean, we're going to have a lot of work to do to get all of our population tested and treated.

CHAIRPERSON LEVINE: Riker's Island, if it were a neighborhood, would have hep C infection rates that are, I believe, double what any other individual neighborhood in the city is suffering from. It's pretty astonishing. Could you describe what you believe is driving that and, more

importantly, what is the city's response to that? That might be an H&H question because I know you manage health care there, but for either of you, care to weigh in on this?

UNIDENTIFIED: So Correctional Health Services aggressively screens patients, ah, aggressively screens folks when they're admitted into Riker's. And we think that some of this more proactive screening is contributing to the higher rates that we're seeing there. But once screened positive they do provide HIV as well as hepatitis C services there, and they can initiate treatment, and so I think the fact that they're screening more aggressively, they're identifying more, and importantly they can start treatment there, and that treatment can be continued once they're discharged from Correctional Health Services and they can be linked to our primary care services, where they can continue to get treatment.

CHAIRPERSON LEVINE: OK. It's one thing if people arrive to Riker's and are screened and you detect the virus, but are there no transmissions while people are at Riker's and can you speak to the frequency of that?

UNIDENTIFIED: I wouldn't be able to speak to the frequency of that. I'd have to defer that to my colleagues in Correctional Health, but we can get back to you on that information.

CHAIRPERSON LEVINE: OK. When you have people living in close proximity one worries about transmission. I think that's an important question, if people are getting, contracting this disease on our watch under, under our care and supervision it would be very disturbing indeed. This is also a very expensive disease to provide medication for. I think it might even be more expensive than PrEP and PEP to offer a full course of treatment to someone who is seeking a cure to hepatitis. Can you also ensure the public that no one will have to forego this treatment because of inability to pay, because of gaps in insurance coverage?

UNIDENTIFIED: Yes. At Health and Hospitals we do our best to ensure that folks can access the necessary treatment and regardless of ability to pay and we would work with insurers to try to get those folks that are eligible for insurance insured, but for those that are uninsured we work to ensure that they are able to access the treatment.

CHAIRPERSON LEVINE: And Dr. Daskalakis, is this also provided out of the sexual health centers?

DR. DEMETRE DASKALAKIS: So we do not provide hepatitis C treatment out of the sexual health centers. We do, however, test individuals who are seeking PEP, PrEP, or HIV treatment for hepatitis, and we do then referred them to care if they have a positive result.

CHAIRPERSON LEVINE: Could you speak to possible insurance gaps as well? Is it similar to HIV drugs or no?

DR. DEMETRE DASKALAKIS: My understanding is that there are definitely some, some gaps in insurance and some insurances that have more complex patterns for prior authorization. I think for the most part the answer is that similar to PrEP and other HIV, well, actually HIV drugs are less of an issue, but similar to PrEP there's a diversity in insurance plans and navigation ends up being a critical piece of how to work with individuals with viral hepatitis to make sure that if they're eligible for insurance that they select plans that would actually support care. Medicaid supports this, as

well as, as, you know, most private insurance, but you do have to have some assistance in making sure that you choose the right plan.

CHAIRPERSON LEVINE: As you're rolling out NYC Care, which is available to anyone in New York City who can't access insurance, but we know heavily that immigrant communities will be relying on it and these are communities which are at high risk for hepatitis, are you building and aiding communication or programming specifically related to hepatitis or HIV as you roll out this very important program?

UNIDENTIFIED: I would have to check with my colleagues in Ambulatory who lead the NYC Care program. I'm not aware of any specific marketing regarding to HIV that's embedded in NYC Care. Certainly with NYC Care we welcome folks with all types of backgrounds and illnesses, and we're willing to, and we're looking forward to treating anyone with any diagnosis that comes through NYC Care.

CHAIRPERSON LEVINE: Thank you very much. I'm going to pass it back to Cochair Rivera.

CHAIRPERSON RIVERA: Hi again. How many individuals living with viral hepatitis and/or HIV in the city receive treatment at an H&H facility?

UNIDENTIFIED: So we don't have complete numbers, but we do know in 2019 we had 1309 patients on treatment in Health and Hospitals facilities, and about 1232 of them were cured. The reason I say we don't have complete numbers is, as you know, we're transitioning our electronic medical record system, so we don't have all of our systems. Today is the first day for Kings County, so we don't have the full numbers on the new EMR. So our reports are only partial. But that's what we're were able to put together for this hearing.

CHAIRPERSON RIVERA: How do you both coordinate to make sure that there is education and outreach done to the patients walking into an H&H facility?

UNIDENTIFIED: So on hepatitis C we actually coordinate very closely. We are, four of our facilities are part of the program Dr. Daskalakis had referred to where we have navigation support. So those programs work very closely with community partners, with clinical providers, as well as with

Correctional Health Services to help patients that are not in hepatitis C treatment navigate to a facilitate that they want to go to, so the patient gets to choose where they're most comfortable, and then we have navigators on our end to receive those patients to help them through. And what you can see from the numbers that I just quoted, really the issue is getting people into care. Once we get them in care we're able to cure them. We're just working now to improve our ability to capture those individuals that have maybe been diagnosed or are undiagnosed and make sure that they get connected into services.

CHAIRPERSON RIVERA: And I guess my last question will be on pregnant people. We have done an incredible amount of work and we want to focus on kind of birth justice and the experience of individuals in New York City accessing care even when they're chronically ill. And I know as few as one-fifth of women who test positive for hepatitis B during pregnancy receive recommended follow-up care for hepatitis B after childbirth. Why is that?

UNIDENTIFIED: We have, we have a women's health council that I know is working really hard at looking at disparities that are recognized in women

and in trying to ensure that they get the full care that women of childbearing age need. So I would, I would really defer and coordinate with them to find out how we can, how we can streamline that process of making sure that we can get patients who may be diagnosed during pregnancy, get the full comprehensive care that they might need postpartum.

DR. DEMETRE DASKALAKIS: Could I just add one thing?

CHAIRPERSON RIVERA: Please.

DR. DEMETRE DASKALAKIS: So we also have a very, at the DOH, robust perinatal hepatitis B program and so we work with women and around childbirth to make sure that all the appropriate prophylaxis is done to prevent transmission of hepatitis B to their newborn, and so of the 1289 infants who were born in 2017 to women with chronic hepatitis B, 99% of them got the appropriate prophylaxis. Part of that then also is to sort of work with sort of the next step, which is navigation for those women for ongoing care, and so we do work with them to make sure that once we're done with sort of the peripartum prophylaxis that they have resources to identify places for follow-up.

CHAIRPERSON RIVERA: And I know that the infants have, you just said 99%, correct?

DR. DEMETRE DASKALAKIS: Yeah, correct.

CHAIRPERSON RIVERA: I'm worried about the mothers haven't, I mean, I saw a stat of one-fifth of women and they're not, I just want to make sure that they're receiving attention and care and that you're working in tandem, and I also know that DOHMH contacted women who gave birth who were reported to have hepatitis B and nearly half of those women couldn't read or speak English. So you are working with community organizations to help meet the needs of these communities?

DR. DEMETRE DASKALAKIS: We have a couple, I have of couple answers to that question. So we are working with community-based organizations, but the exciting thing also is that our perinatal hepatitis B program looks a lot like the community they serve, and so they're able to linguistically deal with them either, in their, in their languages, and so very frequently Chinese is a very significant language, as well as Spanish, and so our team actually is able to communicate with them in their chosen language.

CHAIRPERSON RIVERA: Well, thank you. Thank you for your answers. And I'm looking forward to hearing, if you could send me some information on the Women's Health Council and some of their work, being very, very supportive I would love to be an ally and help with that. So I just want to thank the council member for allowing me to ask so many questions and to you all for your testimony today. Very, very appreciative. And to make sure that I, she was here earlier, but Council Member Ayala had joined us briefly for the hearing.

CHAIRPERSON LEVINE: Excellent. Thank you very much to the administration. Oh, forgive us.

CHAIRPERSON RIVERA: Council Member, Council Member Holden?

CHAIRPERSON HOLDEN: Yes, yes.

CHAIRPERSON RIVERA: Great.

CHAIRPERSON HOLDEN: Thank you, thank you, Deputy Commissioner, for your testimony and your advocacy. I just have a few questions on outreach on these programs. For instance, the Bare it All campaign, how is that campaign delivered? I mean, you said, I think you mentioned social media? How else?

DR. DEMETRE DASKALAKIS: So the first round of Bare it All was in 2017. We had, we had subway ads, Bus Kings, which are sides of buses, we had, I want to say we had four, three or four billboards in areas that we thought specifically needed sort of to get that message because of their service issues.

CHAIRPERSON HOLDEN: Was it about bus shelters too?

DR. DEMETRE DASKALAKIS: Yeah.

CHAIRPERSON HOLDEN: OK.

DR. DEMETRE DASKALAKIS: It was all over. And sort of our typical Department of Health style for a big HIV campaign we used really MTA plus social media. We were on Facebook, we on Instagram, we were on Twitter. And there were some paper components, some palm cards, and those were usually handed out in settings like pride events.

CHAIRPERSON HOLDEN: What method was the most effective? Was it the print campaigns? Was it social media? Did you measure that?

DR. DEMETRE DASKALAKIS: There was an evaluation and we saw a lot of individuals had seen the campaign in sort of public spaces, but also

through digital media. So those two were both effective. I can't tell you much [inaudible].

CHAIRPERSON HOLDEN: But have you measured specifically, because that's important, like how did you find out about this program?

DR. DEMETRE DASKALAKIS: I have to get back to you on that. There was an evaluation. I don't recall if there was, if there was one mechanism that appeared more effective than another.

CHAIRPERSON HOLDEN: Yeah, I'm always surprised how the city has these great programs but they don't really have the outreach. Coming from advertising, I see spaces that are empty sometimes on bus shelters. I see billboards that are in between ads and it's just crumbling, you know, with the paper coming down from the billboard, and I said well why can't we use that, even in down time? And the city doesn't take, I think, enough, or at least they don't put out the outreach. I mean, social media is one thing, but a lot of people can't find it on that, and I think if it's in their neighborhoods on a bus shelter or on, like you said, a subway, that's more effective, I think.

DR. DEMETRE DASKALAKIS: I think we agree that a place-based strategy for where we put our ads, I mean, I'll tell you that when we select our bus lines for our Bus Kings we actually look to areas that have a higher prevalence of the diseases that we're worried about.

CHAIRPERSON HOLDEN: And can you talk about the outreach on hepatitis, because that seems to, a lot of people don't know about the symptoms or at least how do they recognize or how do they get tested. I mean, I haven't seen those ads. I saw them a few years ago, but I haven't seen them.

DR. DEMETRE DASKALAKIS: Yeah, the state recently put out a hepatitis C campaign that they actually did use sort of MTA advertising around the issue of cure. You know, I'll be honest that, you know, one of the reasons that we're able to do large campaigns for HIV is that federal funding for HIV is about two orders of magnitude greater than that for viral hepatitis. And so we really focus our efforts on providers because it's sort of like an easier strategy from the perspective of identifying people to teach them about how test patients and how to educate them and how to treat them, because of the

fact that the federal resources for this are so much lower. HIV does live in a space that there are, you know, we're better resourced to do these large campaigns. So development of the campaigns cost money, but, you know, what you've discussed, placement, is also a significant expense.

COUNCIL MEMBER HOLDEN: But the city, even without like, let's say, enough funds to promote like or to put out a campaign, a print campaign, we could hit social media, so there could be...

DR. DEMETRE DASKALAKIS: That we do.

COUNCIL MEMBER HOLDEN: You are doing it?

DR. DEMETRE DASKALAKIS: Yeah, yeah, we had electronics, electronic and digital media we definitely, that's way more affordable and a lot of our hepatitis work has revolved around electronic media.

COUNCIL MEMBER HOLDEN: OK, thank you.

DR. DEMETRE DASKALAKIS: Oh, no, thank you, great questions.

COUNCIL MEMBER HOLDEN: Thanks.

CHAIRPERSON LEVINE: Great, all right. Now we're going, now I can officially thank you, to

the administration, for your outstanding work and, most importantly, and also for being here today.

DR. DEMETRE DASKALAKIS: Thank you.

CHAIRPERSON LEVINE: And we will go to our next panel, which includes Gail Brown from the Coalition on Positive Health Empowerment, Douglas Worth from Amita Care, Lyndell Orbano, also from Amita Care, Norman Archer from Housing Works, and Gregory Guy Williams from the Alliance for Positive Change. OK. You want to kick us off, Gail? Not yet, the button.

GAIL BROWN: OK, now it's on. Good morning. My name is Gail Brown, and I'd like to than the committee for conducting this hearing and allowing me to give testimony. I'm here not only to testify on behalf, as director of advocacy for the Coalition on Positive Health Empowerment, but also as a long-term survivor of HIV of 24 years. And I want to first congratulate New York City for the outstanding job that they've been doing, especially reaching the goal of 90-90-90. So that's really exciting. But there's still more work to be done, and after I wrote this testimony yesterday I found out that a friend of mine passed who was living with

HIV. So there's definitely still more that needs to be done. So I was here to talk about the barriers to care and some of the ones that I faced and what I've witnessed other people facing in my community are stigma, lack of insurance, high co-pays, appointments that are convenient for doctors and clinics and not necessarily for patients, the number of appointments people have to go to and the lab work, the long waits in the clinic and labs, and patients not being able to communicate effectively with their doctors, also a lack of information given to patients and homelessness. So I'm going to elaborate on a few of those, and I'm going to say that as a consumer it's so challenging to navigate the healthcare system. When I first chose a plan and I worked for New York City, so I have a New York City plan, and when I first chose the plan I had to choose doctors and a medical care facility that I was going to go to, and as an educated person I had such a hard time navigating it. I didn't know who to go to. There were no answers. There was nobody to talk to. There were no navigators. When I called the insurance company they just said go online and find the information. And you go online and you get

information and you see a doctor that has patients open and you look them up and you see that they have pretty good ratings, and then you find out that they don't take any more patients anymore, even though on the directory it said that they did. It took me two years to finally find a place that was convenient and comfortable for me. But I'm also going to share that there were still barriers because one of the barriers is that the ID doctor is only there Wednesday afternoon. That's it. Wednesday afternoon. So if somebody is working, if somebody has kids in school, if somebody has other issues that they have to deal with on Wednesday afternoons it's going to be hard for them to get the care that they need. So I just wanted to share that. The other part was that the first, the first few doctors that I chose had co-pays and I didn't even know that they had co-pays, because the language in the websites is so challenging to read through and figure out. And when you have HIV you have to have a number of apartments. You go to your ID doctor, but then you have to go to a GP and you have to go to, just all the labs and everything, and those co-pays, even though they seem like $10 or $15, you go to five or six doctors it adds up. So

that's also a barrier for some people who just don't have it like that. That's major. Also, what else was I gonna share about. The long wait times to see the doctors, which is a barrier. There are times when I've wanted to leave, when I've sat in doctor offices for two hours waiting for a doctor, and you just go crazy, and a lot of people have left. A lot of people don't stay and wait to see their doctor because it just gets too challenging for them. Another issue is coordination among healthcare providers. And a problem that I had personally was that my, I do mail order pharmacy and the doctors and the pharmacy was not coordinating, and they had taken, the pharmacy used to send me emails all the time when I needed to re-up my prescription. They changed pharmacies and all of a sudden I didn't know, nobody did that, and I went for a whole week without medication because they couldn't coordinate together. And I was on the phone for hours and hours and hours. It was just so hard navigating that system. Even today I had a problem with that because I sent in the order and the order didn't go through. It was just pending and pending and pending. And it took me calling on the phone about three hours to get to

somebody to figure out why it was still pending and to get me my medication on time. And I got it just on time. My life is at stake. So when these people don't coordinate it becomes a really big problem for people when lives are at stake. At COPE we have educational component where we educate people around HIV and hepatitis C, and we find that there are so many people who are not comfortable communicating with their doctor. Sometimes it's the language that the doctor is using that's confusing, that's difficult to understand, especially when patients are anxious about their health outcomes and they're not, they're just not feeling good about what's going on. They feel nervous asking questions because of stigma, language barriers, or just not trusting the system to have their best interest at heart. This is especially true in communities of color, where poverty is prevalent. We found that many patients don't have a thorough understanding of how to maintain their undetectable status. I've heard so many people say oh, I'm just going to take the weekends off because I don't want to take my medication on weekends, or they feel that once they reach undetectable status that they've been cured and

they don't need to take their medication anymore. So I think the medical establishment needs to do much more to educate people to understand how these meds work and that they are not cured just because they reached undetectable status, or that they can't take a vacation. I'm going on vacation, I'm not taking my meds this week. That it doesn't work that way, but people don't necessarily understand that. They also, people are not told that they have to take their medication at the same time every day, which was an issue. So these are things that I think need to be worked on, where we provide more education to patients so that they can maintain their health. Homelessness is also a big issue because it prevents people from keeping [inaudible] and adherent to meds. They can't find their belongings. They can't stay abreast of appointments. They're just moving from place to place, so they don't really remember whether they took their medication or didn't take their medication, and I just want to put in a plug for Housing Works because they're doing a tremendous job housing people. But we all know what's going on in New York City today with people losing their apartments and losing their home and not being

stable, rising rents that are unaffordable, Section 8 housing is becoming less and less. It's almost impossible to find Section 8 housing. And everybody deserves housing and we can't, you know, medical care is housing, you have to have housing to have good medical care and take care of yourself, and it's a right for those people, especially for people living with HIV.

CHAIRPERSON LEVINE: And Gail, we are going to hear from Housing Works momentarily. We didn't actually put the clock on, but since we have a lot of people waiting to testify, maybe you could summarize the rest of your testimony for us?

GAIL BROWN: OK, yeah, I will. Stigma is a big issue, so I'll just leave it at that. That, you know, people are stigmatized by HIV. But what I'd like to just say is to improve care some of the ideas that I had was about insurance navigators which Demetre Daskalakis discussed. More patient-centered community-based care with hours that are convenient for parents and for working people, expansion of school health clinics to include the whole family and not just the student. Ah, mobile medical units that can travel through the community, and there's a few

others here but I'm sure that, you know, housing. With that, thank you so much for letting [inaudible].

CHAIRPERSON LEVINE: Thank you, Gail, and thank you for your incredible leadership in this sector. We really appreciate it. We'll start here, please.

NORMAN ARCHER: Thank you, Chairpersons Levine and Rivera and members of the Committee on Health and Hospitals for hearing my testimony. My name is Norman Archer and I'm here representing Housing Works as a research and policy associate. So Housing Works and the End AIDS New York 2020 Community Coalition are greatly encouraged by the 2018 HIV surveillance data showing that two years ahead of 2020 New York City has become the first city in the US to reach the 90-90-90 goals. We thank the City Council and the administration for your unwavering commitment ending our HIV epidemic. However, we remain concerned about persistent HIV health inequities and realize we have much work to do to end the epidemic. To address these inequities and to further improve our HIV response in order to achieve our 2020 ETE goals, in addition to sustained support for ongoing initiatives, we call for

additional city investments, including the following. We support the proposed legislation to examine HIV-related deaths, but also call for funding to establish ongoing systems to declare both AIDS-related mortality and new HIV infections due to injection drug use as sentinel events. Following each sentinel event the Department of Health and Mental Hygiene field services staff would investigate the case with a high degree of attention to determine whether a transmissional mortality could be averted in order to inform ongoing improvements in our HIV prevention and care systems. To protect the most vulnerable New Yorkers we support the expansion of housing and services for homeless youth and for transgender New Yorkers, regardless of HIV status. Safe stable housing is powerful HIV prevention and care. We are pleased to report that HASA healthcare integration pilot projects are all underway and we urge the council to fully fund the City University of New York evaluation that is essential for your oversight and to inform [scala]. It is time to require access to PrEP at all harm reduction sites and to fund programs that would provide syringe exchange program sites with PrEP education peers and

offset the cost of co-locating harm reduction health services to provide PEP, PrEP, and hepatitis C testing and treatment. This year the Department of Health and Mental Hygiene expanded the Dean Street model to one sexual health clinic in Brooklyn, but further expansion is needed, including a location in Queens. The successful Dean Street model implemented at the Chelsea Sexual Health Clinic must be replicated. We also support the establishment of reproductive health services and transgender health services at all NYC sexual health clinics. Services could be further improved by making syringe exchange services available at all clinics. We are deeply thankful for the council's support of the development of an overdose prevention centers and urge continued funding for a closely monitored two-year pilot of four supervised consumption sites in New York City to research the impact of supervised injection services to reduce drug overdose deaths, HIV, and hepatitis C. We also thank Chairperson Levine and the council for your leadership last year in protecting public health programs from the devastating effects of the New York State Article 6 cuts and we stand ready to work with you again to advocate for restoration of full state

support. We would like to express our support of the proposed legislation that would require the Department of Health and Mental Hygiene to conduct the study of HIV-related deaths and we also support the resolution calling upon the United States Food and Drug Administration to remove any blood donation restrictions based on sexual orientation. Housing Works, along with organizations, individuals, and communities across the city ask the committee's support for ongoing increased investments in these health priorities. Together we can push our AIDS epidemic beyond the tipping point by addressing health inequities and end the epidemic for all New Yorkers. Thank you.

CHAIRPERSON LEVINE: Thank you very much. Please.

DOUG WORTH: Good morning. Thank you for the opportunity to testify. I'm Doug Worth, the president and CEO of Amita Care, which is one of three Medicaid special-needs plans in New York City. We have about 8000 members or at higher risk of HIV. We're proud that New York City continues to be a leader in the fight to end the epidemic. But I'd like to focus my precious time on one aspect of more

work that needs to be done, to focus in on PrEP and the Medicaid program. HIV continues to affect New York City communities unequally. Low-income and communities of color are disproportionately affected. To achieve and end the epidemic goal by 2020 we must increase PrEP access and uptake in the communities most in need of it and ensure that everyone who is HIV-negative has the tools to stay negative. We need to double down on our education and awareness building, on outreach and services and resources that get provided to communities most in need. Medicaid is critical to increasing PrEP update. You heard from Dr. Demetre a lot of the good things that are happening in the city's sexual health clinics. But Medicaid is a huge resource to advance PrEP uptake. Today only 6000 Medicaid recipients statewide are accessing PrEP and that number needs to increase by over, to over 30,000 by 2020. PrEP isn't getting into the hands of those who most need it. Most Medicaid PrEP users are white, but 80% of new HIV diagnoses are among communities of color. Medicaid health plans have a huge role to play in increasing PrEP uptake in the communities most affected by HIV. Medicaid health insurers like Amita Care and

healthcare providers can help by making concerted efforts to improve PrEP access. Plans should educate their members about the availability of PrEP, remove administrative barriers, and cover all of the medication and laboratory follow-up appointments. At Amita Care we know that this is possible because we've done it. In 2017 New York State expanded eligibility for SNPs for like Amita Care to cover people of trans experience regardless of their HIV status. In just two years 25% of Amita Care's transgender members who are HIV-negative are now accessing PrEP. PrEP is a key component of our HIV prevention service. We have over a thousand members of trans experience. In your packet are examples of educational materials that we've produced and sent out to our members. We hold town hall meetings twice a year with members across the city. We have monthly Live Your Life wellness events where we're talking about PrEP and helping people to stay HIV-negative. We've also made sure that our members living with chronic conditions like hepatitis C receive treatment and support. Today we're proud to report that over 1200 of our members who are coinfected with HIV and hep C have been cured. We also link our members to

supportive services. So here's how the City Council can help. Ask mainstream Medicaid plans in New York City to outline what they are doing to increase PrEP uptake within their membership. Collaborate with New York State and press for deeper discounts from drug manufacturers for PrEP medication provided through Medicaid. These discounts will help minimize the cost and ensure that the Medicaid health insurance plans have adequate rates to support PrEP uptake. Thank you.

CHAIRPERSON LEVINE: Thank you very much, and thank you for what Amita Care does for this, incredible community. Thank you.

LYNN DELORVANO: Hi, I'm Lynn Delorvano, director of public policy and government relations at Amita Care. So I'd just like to spend, I won't take the full three minutes, but I wanted to just conclude our testimony by saying thank you to New York City Council for its support for work force programs. It's important that as we address HIV we think about HIV not just in terms of medical care. We have to address all those supportive services that address those social and economic factors that really make people unwell. And having a job is really critical

for good health. If you don't have, it helps to have a home, get food to eat, those basic things that make sure you can take your medications, whether that's HIV medications or hep C medications. And we've, we're fortunate because we've gotten that support from City Council and we have, we've been able to implement an innovative work force program where we work with, we've been able to place 30 people into employment and in addition to that we at Amita Care think it's really important that we hire people, and so we work with Housing Works and the alliance to really employee our members and get them trained properly so that they know how to succeed, or they have the ability to succeed in the work force. In addition to that, we have been, one of the biggest challenges we find is that so over the years we've hired, we've had over 500 [inaudible] workers and we've only been hire about 1% of them, partly because as people, especially for HASA clients, as they work they quickly earn too much and lose their housing assistance through HASA. And so we're working with HASA to make sure that that doesn't continue to happen. In the next year we're hopeful that HASA will get state approval to begin giving, disregarding

more, about 50% of a person's income before they, over a period of five years rather than the current one year so that they can continue to work and really get up to a place where they are working full time and are able to establish themselves in employment before they move, before they are forced to walk back out into the workplace. This is not only a good policy in terms of a person's well-being, but also makes good financial sense. We estimate that it could save the city up to 18 million dollars in just the first year after it's implemented because people would be moving over to full-time employment. And so I'll end there.

CHAIRPERSON LEVINE: All right.

GREGORY GUY WILLIAMS: My name is Gregory Guy Williams and I'm the social director of prevention at the Alliance for Positive Change. I thank the New York City Council on Health and Committee on Hospital for the opportunity to deliver remarks today about HIV and hepatitis in our city. Alliance for Positive Change has been in the forefront of the HIV epidemic for near three decades. When we started this work in the early 1990s as the AIDS Service Center of New York City many people

living with HIV were driven into the shadow by fear, stigma, shame, and misinformation. Our city and community lost thousands of friends, partners, brothers and sisters, and colleagues. It was a dark time, but with treatment advance people are not only living with HIV but they're thriving. The recent announcement by New York State Department of Health that we are the first city in the United States to reach the UNAIDS 90-90-90 goals underscore the staunch commitment and partnership amongst and across community activities, social service providers, medical facilities, health departments, and policy makers. New York City helped write the blueprint to end AIDS in New York State and the results we have seen so far are a testament to the power of collaboration and the investment in strategies that ensure access to prevention, care, and treatment. At Alliance we reach over 15,000 New Yorkers each year through our programs, our broad spectrum of harm-reduction services, help people access medical care, overcome addiction, escape homelessness, rejoin the work force, replace isolation with community, and leads to healthier, more sufficient lives. Alliance programs saves lives. And we urge the city to

continue to expand access to these programs and explore other gaps in accessing programs amongst our community that needs prevention and treatment services the most. Alliance has an extensive peer education program, training, and internship that forms the heart and soul of our agency. Peer program provides skill, opportunity, and a path to employment for New Yorkers affected by HIV and AIDS and other chronic condition. Each year the paid internship, mentoring, support groups, and other services Alliance sponsors over 120 peer interns who inspires the examples of positive change. Armed with skills and information, peers are credible messengers who reach out to people in high-risk communities across New York City, providing screening and education about the importance of knowing your status and connecting to care. Alliance offers testing for both HIV and hep C and we ensure that everyone we screen for has a follow-up appointment with a medical provider. Testing is a gateway to access needed service. And at Alliance we offer the full continuum of harm reduction services from syringe exchange for active drug use through our relapse program and recovery programs. We also treat the whole person,

mind, body, and soul, addressing housing instability, food insecurity, benefits, substance use, mental health, as well as physical health. And I just want to thank the council for taking this time.

CHAIRPERSON LEVINE: Thank you, Mr. Williams. Thank you to the Alliance. The work you do on peer education is just so critical. And thank you to this whole panel. Thank you very much. All right. We're now going to move to the next panel, which includes Richard Saenz from Lambda Legal, Christina Tsai from NYU Langone, Floyd Rumohr from Brooklyn Community Pride Center, Robert Desroloux from the Hepatitis C Mentor and Support Group, Brian Romero from GMHC, and Greg Waltman. You're good. You'll definitely be able to speak. You can grab a folding chair and then we'll scoot you over as soon as the moment is right. And you can kick us off, please, sir.

ROBERT DESROLOUX I'll just get it warm for you. So, good afternoon. Thank you for the opportunity to speak today. I want to thank Council Member Levine and other council members for supporting the hepatitis community in the past. My name is Robert Desroloux and I'm here today as a

representative of the Hepatitis C Mentor and Support Group. I have been working for six years on the ground with underserved communities, providing training on education and supportive services within the syringe exchange programs and drop-in centers. I work closely with the founder and executive director of Hepatitis C Mentor and Support Group, Ronnie Marks, who in addition to being a patient has experienced working with both patients and providers. Educational groups and supportive patient mentoring services have been shown to be an important element of successful and cost-effective medical care for patients with hepatitis C and other chronic health conditions. These services improve the quality of life as well as medical outcomes for patients. The training HCMSG provides for healthcare providers to help them have better understanding of how to work with all patients within an emphasis on high-risk populations, such people with substance use disorder, those coinfected with HIV, the LGBTQ community, women, and youth, youth and women of childbearing age dealing with hepatitis C. Our hope is to see, our hope is to see us provide a model for the entire country with NYC as the first city to eliminate

hepatitis C. We need to increase services for hepatitis, peer navigators, harm reduction and syringe exchange services. This is why it's critical that we reduced missed opportunities to screen and diagnosis patients who seek care in emergency rooms and hospitals as well as educating providers and staff on the stigma faced by people who use drugs. There are opportunities to move forward, move towards elimination by increasing the focus on treating patients who are in the hospital for extended periods of time. Education is needed in overdose prevention, hepatitis C, and HIV. People need to understand this endemic connection between substance use and infectious disease. As an educator in the field and someone who has witnessed the lack of knowledge in these communities, I can tell you first-hand what an impact the virus has on the lives of those affected. There is such, there is such power in having supportive services and patient navigators. It is essential for patients to work with people who understand what they are going through and can help them through the process, making it easier for patients to adhere to treatment. In many cases, it has helped to reduce a feeling of stigma associated

with having hepatitis C. Please help us and ensure that all New York City residents have access to hepatitis C testing, treatment, and care regardless of race, gender, and/or economic status. I want to thank the council for hearing our testimony today.

CHAIRPERSON LEVINE: Thank you so much. Appreciate it. Please.

CHRISTINA TSAI: Good morning, Chairwoman Rivera, Chairman Levine, and all council members present. My name is Christina Tsai and I am the site director at Seventh Avenue Family Health Center, a federally qualified health center that is part of NYU Langone Health System. We are located in Sunset Park, Brooklyn, and we serve over 5000 unique patients per year, which generates more than 30,000 visits annually. Over 95% of our site's patient population are Chinese immigrants from the southern part of China. Our team of physicians and staff provide primary care services to low-income families in the community, which include migrant workers and undocumented persons. Thank you again for giving me the opportunity to testify about the city's efforts to prevent and address hepatitis. And to speak specifically about the city-funded Check Hep B

program. On behalf of my team at Seventh Avenue Family Health Center at NYU Langone, I hope to convey the importance of the Check Hep B program and to encourage your support for increased funding for the program. As we have heard from other testimony today, the Check Hep B program is a vital component of the city's efforts to address hepatitis. Participating in the Check Hep B program has enabled our center to link a growing number of identified individuals to care, to provide hepatitis B screening, testing, and to better educate patients about the disease itself. The Seventh Avenue Family Health Center is currently the only location in Brooklyn that is providing these crucial services through the Check Hep B program. And, again, I must stress we are the only location in Brooklyn that is funded through the Check Hep B program. It's well documented that the populations in our area in Brooklyn are at high risk for hepatitis B. Hepatitis B is very common in East Asian countries and Sunset Park, Brooklyn has one of the largest Asian immigrant communities in the New York City area. Since we talked a lot about a data already I'm going to skip that portion, but the point I really want to make

clear is that many people currently living with hepatitis B in Sunset Park are not aware that they have the infection. And some realize that they are hepatitis B positive only when symptoms appear, which can be during later stages of the disease itself, and although we have received funding through the Check Hep B program we have enrolled the largest number of patients to date out of all the funded organizations, and that's 337 patients to date. We also have the highest number of enrollments per year. However, in terms of funding allocation it's not sufficient, as compared to some of the other funded organizations. So I really greatly appreciate the opportunity to testify and welcome any questions you may have about my facility and the Check Hep B program.

CHAIRPERSON RIVERA: I wanted to ask you a question.

CHRISTINE TSAI: Sure.

CHAIRPERSON RIVERA: In my testimony I mentioned that hepatitis B disproportionately impacts living in Sunset Park.

CHRISTINE TSAI: Correct.

CHAIRPERSON RIVERA: so I'm very grateful that you're here. And we also known that Asian or

Pacific Islanders are twice as likely to die from hepatitis B than other communities.

CHRISTINE TSAI: Correct.

CHAIRPERSON RIVERA: So in terms of how you're engaging with these communities, um, how we're engaging, what would you say are some of the biggest challenges? I know that you said funding.

CHRISTINE TSAI: Sure.

CHAIRPERSON RIVERA: You don't feel like you're receiving adequate funding.

CHRISTINE TSAI: I think it's just in general about increasing awareness of hepatitis B, because I think many persons with the disease itself, they don't realize they even have a health problem until they start having symptoms. So the way that we are trying to be proactive at my facility is that during routine office visits, like annual checkups, my primary care physician team are already doing hepatitis B screening and testing, and this is well before we even, were enrolled in the Check Hep B program. But what this grant has allowed us to do is to employ a full-time patient navigator who speaks Mandarin, Cantonese, and multiple other Chinese dialects, to engage with patients and we get a lot of

referrals from the Department of Health as well, which has been very helpful. And many of them are undocumented or uninsured patients. So that has helped us increase awareness. But I think it really is word of mouth. As much as social media and other avenues can help, but it's really word of mouth and facilities such as myself where we provide primary care services, and it has to become part of routine care.

CHAIRPERSON RIVERA: And I ask Health and Hospitals this question. I didn't receive a lot of information, but hopefully they'll get back to me, about pregnant persons and receiving that, that care, um, those who test positive receiving recommended follow-up care. Are you experiencing that in your facility?

CHRISTINE TSAI: So I know that our facility actually worked with the Department of Health on this initiative and there were a few cases, I don't recall the exact number, it was really through my medical director, my clinical team, um, so I'm more of the site operations lead. So in terms of all the cases that were reported to my medical

director at the facility, those been resolved or being closely followed.

CHAIRPERSON LEVINE: OK, great, thank you for all your...

CHRISTINE TSAI: No problem.

CHAIRPERSON RIVERA: Thank you.

CHAIRPERSON LEVINE: Please, sir. Thank you.

FLOYD RUMOHR: Good morning. My name is Floyd Rumohr. I want to first thank the, ah, Council Members Rivera and Levine for welcoming me here today, and for this opportunity to testify regarding the city's efforts to prevent and address HIV and hepatitis. My name is Floyd Rumohr and I'm the CEO of Brooklyn Community Pride Center, the first and only LGBTQ community center located in and serving the residents of Brooklyn, and more personally I am a living representative of the successes referenced by Dr. Daskalakis and CM Dromm, having lived with HIV for 30-plus years and been cured of hep C. Our center is located in Bedford Stuyvesant and we have exciting plans to open a second location in 2021 in Crown Heights. Those locations were chose with a purpose. Both neighborhoods continue to lead the city in

highest rates of new HIV infections. We acknowledge that the city has put many resources into these Brooklyn neighborhoods to help combat the spread of HIV and other STIs. We partner with many of the wonderful organizations like NYU Langone Family Health Centers, who are among our virtual community partners, including and in addition to that our on-site full-time partners include CAMBA Young Men's Health Project, Turning Point Brooklyn, and Oasis Latinx LGBT Wellness Center, just to name a few. Even as we offer testing and education seven days a week through these partnerships, we also strive to keep the balance of being a brave space for people to relax and express themselves without feeling like numbers in somebody's grant application or research project. This is difficult to balance, to maintain a balance, because with more than half all new infections including in the MSM community, much of Brooklyn is still sadly lacking in queer-affirming spaces, where the population most at risk will feel comfortable, seeking testing, education, and advice. For our black and brown community members, who account for almost half of new infections in 2017, it is especially challenging to be told that accessing

HIV and sexual health services, and explicitly LGBTQ+ affirming spaces means getting on buses and trains and traveling into predominantly white, predominantly upper class, gentrified neighborhoods in Manhattan. As you consider your longer-term strategies to combat HIV and STIs in New York, especially in the outer boroughs, I'd like to request that we remember that all LGBTQ+ competency training and targeted outreach you can fund isn't as effective as have been nearby accessible, explicitly LGBTQ-affirming brave spaces like Brooklyn Community Pride Center for people to comfortably and organically connect with the lifesaving programs and services already in place in neighborhoods where people live. I invite you and everyone here to drop in and visit us at Restoration Plaza, just off the corner of Fulton Street and New York Avenue, to see how we're creating such lively, affirming spaces. Thank you.

CHAIRPERSON LEVINE: Excellent. Thank you very much. And Brian?

BRIAN ROMERO: Good afternoon, Chairpersons Levine and Rivera, and to the committee members who are present. My name is Brian Romero. I use he/his pronouns and I'm a policy associate at the

Gay Men's Health Crisis, or GMHC, which is the first organization to be founded to respond to the HIV/AIDS epidemic. Thank you for the opportunity to testify today. At GMHC we're encouraged by the recent 2018 surveillance report of the New York City Department of Health and Mental Hygiene. For the first time in New York City's history we have achieved less than 2000 new diagnoses a year since we started recording this data. This does not, however, yet meet the goal of the Ending the Epidemic Task Force and Blueprint that set a goal of seeing no more than 600 new diagnoses coming from New York City. We also cannot underestimate the significance of where we have seen an increase in new diagnoses. As was stated in the report, between 2017 and 2018 we saw an increase among transgender people, people between the ages of 50 and 59, men who have sex with men, and men who inject drugs. We have also still not seen the reduction in diagnoses among men of color who have sex with men that we have seen in their white counterparts. What can be done in this regard is increasing access to pre-exposure prophylaxis to these populations and to men of color as well. In addition, without the adequate funding necessary to

support these and other initiatives related to healthcare access and provision of services, we will not see the outcomes we hope for. Earlier this year in Albany over 60 million dollars were slashed in Article 6 funding, threatening programs and services in New York City, such as those that support immigrant health, health education, health insurance access, HIV/AIDS prevention and treatment, child and maternal health, transgender health equity, viral hepatitis, and more. Therefore, we strongly urge that the council do all that it can to advocate for this funding to be restored when it visits Albany. We need Albany to prioritize this in budgetary deals if we are truly going to end the epidemic in New York City and State by 2020. In addition, as we are speaking about Albany, I am saddened to say that at this moment there is a bill on the governor's desk which is facing a threat of veto, which would provide post-exposure prophylaxis to young survivors of sexual assault. Finally, as an organization that has worked on the discriminatory blood ban on men who have sex with men, we urge the council to pass Resolution 0150, which would urge the Food and Drug Administration to discontinue its blood ban based on

sexual orientation. The ban is based in homophobia and we cannot afford to continue these restrictions with the blood shortage that exists in this country. Lives are depending on this change. Thank you for the opportunity to testify today.

CHAIRPERSON LEVINE: Brian, why would it even be controversial, the question of providing PEP to survivors? What, I realize you don't support that position, but what possible argument could there be against it?

BRIAN ROMERO: Chairperson, I believe you'd have to ask the governor, but as we understand it, the fiscal implications, though that paired with the ability to provide, again, survivors of sexual assault, minors, with PEP is not something that we understand as well.

CHAIRPERSON LEVINE: It's a potentially lifesaving intervention. I can't imagine any fiscal argument against it, but thank you for bringing it up today. We will certainly push for that, the enactment of that important measure.

BRIAN ROMER: Thank you, Chairperson. I urge everyone here today to go onto social media and

tweet and let the state know that this is something that is being threatened at the moment.

CHAIRPERSON LEVINE: Thank you.

RICHARD SAENZ: Good morning. My name is Richard Saenz. I'm a senior attorney at Lambda Legal, based here in New York City. We do have offices across the country. We welcome the opportunity to testify in support of the resolution calling for the FDA to remove any blood donation restrictions based on sexual orientation. Lambda Legal, we are the oldest and largest national organization dedicated to the civil rights of LGBT people and people living with HIV. And we're, we do this work by bringing impact litigation, our public policy work, and community education and outreach. Through our HIV project, Lambda Legal litigates and advocates for the rights of people living with HIV. And I always add and our friends and families and community members, because, as we know, it's not just the person who's living with HIV, but it's their support networks and families that are also impacted. Through our ligation we combat HIV-related stigma, bias, and misinformation. Lambda Legal, we won the first the HIV discrimination case in the country back

in 1983, and we have fought to promote and defend the rights of people living with HIV across the us and to advance the use of accurate medical and scientific evidence as a basis for legal decision-making regarding the rights of people living with HIV, as well as in prevention efforts. We support the resolution and would encourage that the resolution make explicit that while calling for the FDA to remove any blood donation restrictions based on sexual orientation that the FDA replace this with an individualized behavior-based risk assessment for all donors. The resolution acknowledges that the American Medical Association has called for individual testing assessment instead of the blanket policy based on sexual orientation. And Lambda Legal has advocated for years for a policy with a shortened deferral period that is based on the conduct of the potential donor rather than the donor's sexual orientation or gender identity. As our, as Lambda Legal's HIV project director Scott Chada said, an evidence-based policy would focus exclusively on the conduct of the potential donor, rather than the person's identity with regards to sexual orientation, gender identity, or perceived risk factors based on

the person's identity. Risk behaviors do not have a sexual orientation or gender identity. Within 45 days of exposure currently required blood donation testing detects all known serious blood-borne pathogens, including HIV. Therefore, deferring anyone longer than two months is not necessary and does not discernibly enhance the safety of the blood supply. Lambda Legal supports the resolution and will continue to work towards real reform in our nation's blood donation policy. Thank you.

CHAIRPERSON RIVERA: I just have a quick question, because we, you know, black women are eleven times more likely to be diagnosed than white woman, and I'm, and I'm curious to the panel as to what are, how do we, what are the links to that? How does that happen and what are, what is the support that you are all receiving in your work to make sure that we addressing this population? Anyone?

CHRISTINE TSAI: Well, 95% of my patient population are of Chinese descent, but Family Health Centers is a large network that is part of NYU Langone. So for example we have a FQHC that's part of system called Flatbush Family Health Center and in terms of addressing their needs, a lot of it is due

to community outreach partnering with the local community-based organizations and just, again, I think, um, we have to ingrain it with what we do in terms of every-day primary care services. Because we find when we tell patients to come to our facilities for care for a specific reason that even though we're trying to address as an epidemic potentially, the patients don't see that. They don't get that. So the only way to make that where we can get them into the site is to explain to them during another routine office visit reason.

BRIAN ROMERO: I would just add that it was said before that we cannot have this conversation without addressing social determinants of health. And while at GMHC black women are not a substantial portion of the clients we serve, I would also add that it is important in PrEP navigation that those professionals look like the communities that we serve, and so that is just one thing that I'd add in terms of this conversation.

CHAIRPERSON RIVERA: Thank you.

CHAIRPERSON LEVIN: And Mr. Saenz, on your very important point about modernizing our rules around blood donation and why that's clearly

consistent with science at this point, is the pushback, is it again a resource question? What, what would be the argument in 2019 to reject that important supply of blood?

RICHARD SAENZ: Ah, I think that's an important question. I think it's, ah, my understanding is, is the last time we submitted comments to the FDA on this was back in 2015. So we're now at point in 2019 with this resolution and other activity trying to push for even more exchanges. So I think as the science continues to expand and we just know more, it's a little bit of catch-up for the FDA and whatever other factors and considerations, I mean, it's up to government to explain those, but I think the science does support these changes.

CHAIRPERSON LEVINE: It would really be terrible if what I think we can all agree is persistent homophobia prevented people who want to help save the lives of other Americans from doing so, we're not in a position to waste any donated blood, and to tell a whole class of Americans no thank you is just insane, especially when the science is beyond clear on this. So we definitely stand with you on

this fight. Did you want to say something, Brian, on that?

UNIDENTIFIED: I thank you, and I do want to, we do have some recent historical evidence of this. After the massacre at Pulse Night Club we saw that people who weren't even aware of this ban were being faced with not being able to, to make the donations.

CHAIRPERSON LEVINE: Truly, it makes no sense whatsoever. Please, Brian.

BRIAN ROMERO: It doesn't make sense. I would just also add, because I was in some ways like the [inaudible] that you asked, compared to Canada they have instituted a three-month restriction, and even then that the science doesn't support that. So I would say we're even behind on that, so.

CHAIRPERSON LEVINE: Is there another nation which is doing this right?

BRIAN ROMERO: I'd have to get back to you on that.

CHAIRPERSON LEVINE: OK.

GREG WALTMAN: Good afternoon, council members, general council. Greg Waltman, representing a clean energy company. But today I'll be talking

more privately about myself and as it relates to surveillance type issues interrelated with HIV and seems hepatitis issues. When I was 16 I was diagnosed with cancer, chronic myelogenous leukemia. And it's a translocation of the ninth and twenty-second chromosome and caused different type of bone marrow issues. And I received a bone marrow transparent. And that was super positive, not only in remission but, but cured. Obviously bone marrow transplants are now a viable option for HIV/AIDS and those types of related sicknesses, although expensive options. Just parsing that all together. But speaking from a surveillance type of issues, you know, one of the colleagues previously to this panel testifying speaking about AIDS surveillance, and you hear about Google and now receiving millions and millions and millions of Americans' data, at what point is that data now a value issue where they're taking the information and holding it against different types of citizens, whether it be for any different types of fiscal, monetary, or different types of fraudulent reasons to accommodate, you know, several, several types of criminality that I brought to your attention more or less involving Jamie

Diamond, shadow banking, insider trading, and the type of criminality, manipulation, and fraud involved in Ukraine. So I'm just kind of parsing that together. But when someone has a legitimate complaint and brings it to your attention and someone like a central banker, someone from a big value corporation gets a hold of the data, you know, how, and at what point are ads and parsing the data into ads not just in advertisement but become wire fraud? When are those wire frauds then kind of addressed in a type of criminality or a type of element, judiciary type of context that it then becomes resolved, you know, and just to go back to my colleagues' speaking about HIV/AIDS, George Church from Harvard University, he does x-ray crystallography and has many advances in genetics and molecular genetics and you're right, you know, when you're talking about the different types of issues and dealing with blood pathogens and other types of things there are concerns, but many of those laws were evoked kind of in the Seventies and Eighties and as we sit on these old laws, obviously the science has advanced in the type of way and capacity that warrants a type of consideration from not only the panel but other

lawmakers as well. So I just, I just wanted to bring that to your attention and reanimated in the type of big data, trillion-dollar data value big data context where ads aren't really ads. It's more wire-wire dragnets with the intent to entrap and do other types of things for, to other types of public citizens and if there's no accountability, you know, that becomes a type of privacy issue. There are HIPAA laws and other types of things. But, you know, addressing that in the proper judicial context would be more than appropriate. Thank you for your time.

CHAIRPERSON LEVINE: OK, we thank you. And I want to thank this panel and the previous panel. We talked a lot about the heroic work of the health department and the progress that we've made against HIV, but the CBO community, the advocates, the public health professionals, you all have really led us. You've led the city now for decades. So we really are grateful for what you have achieved. There's much more work to do. That's what today has been about. But I do want to express gratitude for the leadership of everyone in this panel and the previous PA and lateral, and so many others in the

advocacy and provider communities. Thank you. And this concludes

C E R T I F I C A T E

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

Date December 14, 2019