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TRANSCRIPT OF THE MINUTES

Of the

COMMITTEE ON HEALTH

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B E F O R E:
COREY D. JOHNSON
Chairperson

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Rosie Mendez
Mathieu Eugene
Peter A. Koo
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A P P E A R A N C E S (CONTINUED)

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CHAIRPERSON JOHNSON: [gavel] Good afternoon, everyone. My name is Corey Johnson, and I am Chair of the Council's Health Committee. I want to thank you for joining us today for today's hearing on evaluating efforts to improve surveillance, testing, treatment, outreach and education relating to Hepatitis B and Hepatitis C. As well as the hearing on Proposed Introduction No. 51-A requiring the Department of Health and Mental Hygiene to issue an annual report regarding Hepatitis B and C. I would like to thank my co-sponsors on this bill, Council Members Chin and Koo, who are with us, and for their leadership on this issue.

Hepatitis B and C both can cause chronic persistent infection, which can lead to liver disease. These are two illnesses that are generally under-reported, and for which there is not a lot of screening. Additionally, transmission for both diseases is similar in that babies are at risk at getting the infection from their mothers at birth, and injection drug users are at high risk. Of course, despite this overlap, these diseases come with an important difference in terms of risk factors. Consequences for the patients, courses of

treatments, and kinds of interventions used to reach those who are infected or most at risk of being infected.

There are about 100,000 HBV infected people in New York City, many of whom are immigrants who contracted the infection in their country of origin where there is limited access to Hepatitis B vaccination or for mothers who were not vaccinated. There is no cure for HBV, although there are drugs that can slow progression of Cirrhosis, and reduce the likelihood of liver cancer. Screening for HBV is critical, as up to two-thirds of people infected with the virus are unaware that they have it. This is why outreach, education, and screening efforts for HBV need to be conducted in a culturally and linguistically tailored way. So that non-native English speakers who are infected can be identified, linked to care, and educated on how to reduce transmission to others.

Hepatitis C in some ways paints a very different picture. Those most chronically afflicted with HCV are Baby Boomers, a group that makes up about 75% of the chronic HCV population in the United States. African-Americans have a higher rate of

chronic HCV than other ethnic groups. And while there is no vaccine for Hep C, thankfully, there is now a cure. And this profoundly welcomed news for Hep C patients, though this good news comes with caution, as this is still a disease for which most people do not know they are infected. We need to devise ways to get people tested so they can learn of their status and get linked to care.

Additionally, the cure is expensive, and for many it is not covered by health insurance or is out of reach for the uninsured. Importantly both Hep B and C often go undetected making them silent killers, which means our outreach, screening, and detection efforts are essential. I look forward to hearing from the Department of Health, and the Health and Hospitals Corporation, and other advocates about how we should -- what we should be doing as a city to address these diseases to meet the needs of those who are infected or at risk of being infected. We want to hear about what works, how we target those most at risk, what more is needed, and what kind of interventions are key.

I would like to take a moment to applaud the efforts of the City's Department of Health and

HCC on both Hep B and C. DOHMH has been a brilliant leader in efforts to combat these diseases. Under the thoughtful leadership of individuals like Dr. Jay Varma, Dr. Fabienne Laraque and their staff, we have seen tireless work, innovative thinking, great community-based partnerships, and support for culturally appropriate initiatives. And we are also going to hear today from HCC, and a number of incredible advocacy organizations and providers who have been pioneers in this field. This is the kind of work we need to see more of across New York City. I welcome DOHMH, HHC, and the advocates to advice the Council on ways we can be supportive on these efforts. I know that funding is a good start, and we are working on that.

My hope is that we can build on this record here today, and all of the great work that advocates and providers do with an annual report that is meaningful and reliable data. We can establish a platform to continue advocating for programming that will help us make significant advances in this area. This bill, of which I am a co-sponsor, will be crucial in helping the Council and public get a handle on the urgency of treating this disease and

how to design the best interventions we can address on these problems. I look forward to hearing from our witnesses today, and to working with advocates, and the bill sponsors to make this effective -- to make this an effective tool, and to see it through to the end.

Lastly, I want to acknowledge my colleagues on the Health Committee who have joined us here today, Council Member Arroyo, Council Member Eugene, and we are also joined, as I said, by my co-sponsors on this important piece of legislation, Council Members Koo and Chin. I want to thank my Legislative Director Louis Cholden-Brown; Health Committee Counsel Dan Hafiz; Policy Analyst for the Health Committee, Crystal Pond; and Crilhien Francisco, the Finance Analyst for the Health Committee. And I also want to thank Corey Furcel [sp?] in their work in preparing for this hearing.

We will now hear from the prime sponsor of this bill, Council Member Margaret Chin followed by Council Member Peter Koo. I turn it over to Council Member Chin.

COUNCIL MEMBER CHIN: Thank you, Chair. Good afternoon. I'd like to begin by thanking member

Johnson for chairing this important oversight hearing. I would also like to thank both Council Member Johnson, and Council Member Koo for working with me to introduce the legislation we will focus on today. The legislation we introduced in February, Intro No. 51 would require the City's Department of Health and Mental Hygiene to publish an annual report on its efforts to identify and prevent the spread of Hepatitis B and C. Hepatitis is a deadly and widespread disease. In addition, Hepatitis B is especially prevalent among our city's Asian population. And Council Member Koo and I have seen the horrible toll that disease has taken within our districts. What makes Hepatitis infection particularly dangerous and difficult to prevent is that many people carry the disease without even knowing it.

It saddened me to hear studies, which suggest that one in 12 Asian-Americans are infected with Hepatitis or that two-thirds of those who are infected may be unaware of their status. When we hear reports like that, we know that we must act. We know we must work hard here to gain more information about this disease, and to better educate the public

so that we can fight it more effectively. That is the goal of our legislation. A key element of the bill is that an annual report would raise awareness about Hepatitis throughout the city, in the Asian community, in the LGBT community, in all of our communities.

Another key element is annual report that would give lawmakers, health providers, and Hepatitis advocates the tools they need to cut down on new infections. We understand that as with any city agency a new mandate for annual Health Department report may require more resources within that department. We are committed to fighting for more resources for that purpose if they are necessary. But we feel that much of the raw data regarding Hepatitis is already available, and that it can be put into action with the resources we have now. We believe that turning that raw data into more effective information with greater details and contacts will not place an undue burden on the Health Department. Simply put, we feel very strongly that the benefits of an annual report far outweighs the cost.

We are grateful for the feedback that the Health Department has already given us on the legislation, and we have incorporated most of your suggestions in our current version of the bill. We also welcome the Department's testimony today. In the end, this is about saving lives. So we hope we can work together with you all to achieve a result that would be practical, useful, and will help us save those lives. Thank you for being here today, and thank you, Chair.

CHAIRPERSON JOHNSON: Thank you Council Member Chin. Council Member Koo.

COUNCIL MEMBER KOO: Good afternoon, Mr. Chair, colleagues, staff, advocates, and members of the public. I am happy to be here with all of you today. Thank you, Chair Johnson for holding today's important hearing. I appreciate your leadership, and willingness to address this important subject. As many of you are aware, Hepatitis is a dangerous viral infection of the liver. It tends to affect immigrant communities. In particular, Asian-American communities. What makes Hepatitis dangerous is that though you can be treated, many people do not know they have the infections because they look and feel

healthy. In fact, many people go symptom free for a long period of time, and only find out they are infected after it has become a serious matter. As a pharmacist, I have seen first hand how this disease can affect people and families.

That is why outreach and prevention efforts are so important. Even before being elected to the City Council, I would hold seminars to educate people, and make them aware of the dangers of Hepatitis, and encourage everyone to get tested frequently. The more conversations we have about this disease, and the more people who are made aware of it, the more lives we will save. That is why I partnered to sponsor this bill that we are hearing today with Chair Johnson, and Council Member Margaret Chin. I look forward to beginning this conversation. And to hearing everyone's testimony on this vital topic and this important piece of legislation. Thank you, Mr. Chair.

CHAIRPERSON JOHNSON: Thank you, Council Member Koo. We've been joined by Council Member Espinal, and before I turn it over to folks that are going to testify, first I have to swear you in. So if you would 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? Thank you very much and let me turn it over to Dr. Varma to begin.

DR. JAY VARMA: Great. Thank you very much. Good afternoon, Chairman Johnson, and members of the Health Committee. My name is Dr. Jay Varma and I'm the Deputy Commissioner for Disease Control at the New York Department of Health and Mental Hygiene. On behalf of Commissioner Bassett, thank you for the opportunity to testify today on this important issue. Because this is the first time that I have had the opportunity to testify before the Committee, I'll briefly describe the roles played by the Health Department as they relate to infectious disease control.

I oversee all of the infectious disease control programs at the Department, which includes separate programs for HIV, sexually transmitted diseases, tuberculosis, vaccine preventable diseases, general communicable diseases, as well as a public health laboratory. Our programs for general communicable diseases, vaccine preventable diseases,

HIV and the public health laboratory, all play an important role in the control of viral Hepatitis. The bill under consideration today, Introduction 51-A, is intended to raise awareness about two important causes of illness and death in New York City; Hepatitis B and Hepatitis C. Although they share a common name, the viruses are distinct. The prevalence of each varies widely across different populations of New Yorkers, and the two viruses require different control measures. Therefore, I will talk today separately about each of these diseases. The Department greatly appreciates the Council's interest in these areas, and in the value of data reporting. However, we are concerned that the reporting mandated by this bill would place unnecessary requirements on financial constrained programs. We are interested in working with the Council to ensure that this legislation does not inadvertently pull resources from poor programs that identify and treat viral Hepatitis in New York City.

Let me begin first by discussing Hepatitis C. Hepatitis C is a virus that is transmitted by contact with infected blood, most often from an unsafe injection. There is no vaccine

to prevent Hepatitis C infection. Therefore, the primary strategy to control Hepatitis C includes reducing unsafe injections to prevent new infections, and testing and treating already infected people to prevent death. We estimate that 146,500 New Yorkers are living with the Hepatitis C infection. The highest infection rates occur among Hispanics and non-Hispanic Blacks, and they occur in the South Bronx and East and Central Harlem. The annual death rate from this disease has increased 46% of the past 15 years in New York City.

Until recently, very little testing and treatment has been performed for Hepatitis C because drugs to treat it were toxic and ineffective. In the past year, new drugs have become available that can cure Hepatitis C by taking a few pills everyday for only a few months. We estimate that only 50% of infected New Yorkers actually know that they are infected, and fewer than 10% of infected New Yorkers have ever been treated for Hepatitis C. The Health Department works closely with our community partners to educate the public, and doctors about testing and treatment. It's essential for more physicians to be trained to treat Hepatitis C, and to develop larger

scale public health programs to help navigate patients to appropriate education and treatment services.

Despite large cuts to our Disease Control Programs in the past ten years, our team is working assiduously on Hepatitis C. In 2013, the Department released and action plan to reduce illness and death form Hepatitis C in New York City. Major activities that the Department has undertaken to implement this action plan include developing educational content for the public, such as redesign of our Hepatitis web pages; production of new print and video materials; and development of an app for patients. We've developed educational content for healthcare providers, and worked with providers to improve testing practices, and to provide training in Hepatitis C.

Continued implementation of the Check Hep C Project, which involves education, testing, and linkage to care for patients in high prevalent settings; working to expand services and syringe exchange programs; to address increases in injection drug use and Hepatitis C infections among young people; building community resources and advocacy

through the Hepatitis C task force; and amending the New York City Health Code to permit more complete monitoring of testing and treatment in New York City.

Now, let me turn to Hepatitis B. Like Hepatitis C, Hepatitis B can also be transmitted by contract with infected blood. Unlike Hepatitis C, however, Hepatitis B can also be transmitted readily by contact with semen or other body fluids. Even more important, a highly effective vaccine to prevent Hepatitis B infection has been available in the United States since 1981. The primary strategy to control Hepatitis B in New York City therefore involves preventing new infections through vaccination. An estimated 100,000 New Yorkers, however, and currently living with Hepatitis B virus. Chronic infection is most common in Sunset Park in Brooklyn, Flushing in Queens, and China Town in Manhattan.

Of patients with chronic Hepatitis B infection, over 90% of them were born outside the United States. The majority of them in China. Routine vaccination of all newborns in New York City began in 1991. Because Hepatitis B vaccination is a school immunization requirement, more than 95% of all

children less than 18 years of age in New York City are fully immunized. The Department also places a high priority on immunizing adults who are at very high risk, and on preventing transmission of infection for infect mothers to their newborn babies. Our sexually transmitted disease clinics offer Hepatitis B vaccination to high-risk populations, as does our immunization clinics and our correctional health services. And our Vaccine Preventable Diseases Program case manages approximately 1,800 pregnant women with chronic Hepatitis B each year, 91% of whom were born outside the United States. We work with these mothers and their physicians to ensure that their newborn babies receive both an immunoglobulin injection and vaccination promptly and completely after birth to prevent acquisition of Hepatitis B infection.

A major gap in the health system is that there are limited resources for those people who are already infected with Hepatitis B. First, there are no medications that can reliably cure Hepatitis B infection. Treatment with a combination of medications can help prevent damage to the liver, and prevent liver cancer, which is the most serious

complication of the infection. But the cost of drugs alone exceeds more than $50,000 per patient per year. Second, as noted above, most infections occur in immigrants from China, many of whom are not eligible for health insurance.

So now, let me turn to the legislation proposed. The Department shares the Council's concerns about Hepatitis B and Hepatitis C. We are concerned, however, that this legislation imposed a work burden that extends the Department's staff beyond its current resources. In previous years, we produced a consolidated report about Viral Hepatitis. We were able to produce that report because we had a grant from the Centers for Disease Control specifically for Viral Hepatitis Surveillance. We lost this grant in 2012, which meant that we no longer had funding for seven staff that were previously dedicated to working Viral Hepatitis. Nevertheless, the Department has continued to work to ensure that the most important accurate data about this disease is publicly available even if it's not in a printed report. The Department's EpiQuery system now includes data about Hepatitis B and Hepatitis C. And this can be easily analyzed by

anyone through an interactive and user-friendly system on the web.

We are also concerned that some of the data elements requested in the Council's proposed legislation cannot be reliably measured such as acute Hepatitis B and C infections, liver cancer deaths due to Hepatitis B and C, adult vaccinations, and the percentage of Hepatitis B and C cases referred to care or currently in care. The Department does look forward to working with the Council to improve this legislation, and to further broaden awareness about Hepatitis B and Hepatitis C. Thank you for the opportunity to testify today, and I'm happy to answer any questions.

CHAIRPERSON JOHNSON: Thank you, Dr. Varma. Dr. Joseph Masci from HHC Elmhurst Hospital.

DR. JOSEPH MASCI: Good afternoon, Chairperson Johnson and members of the Health Committee. I'm Joseph Masci, Director of Medicine at Elmhurst Hospital Center, which is part of the New York City Health and Hospitals Corporation. I'm also a Professor of Medicine and also preventive medicine at the Icahn School of Medicine at Mount Sinai. On behalf of HHC, thank you for the opportunity to

testify today on efforts to increase screening treatment and education for Hepatitis C and Hepatitis B.

As you know, Hepatitis is a disease that inhibits the proper functioning of the liver, and is the leading cause of death due to liver disease. The three most common forms of Hepatitis are Hepatitis A, Hepatitis B, and Hepatitis C. Hepatitis C or HCV is the leading cause of liver cancer emanation with mortality rates that have now surpassed that from AIDS. In the United States, 3.9 million Americans are estimated to be infected with Hepatitis C, and 65 to 75% are unaware of their infection. Unfortunately, many of these individuals are not receiving care. Hepatitis B, HBV, is 100 times more infectious than HIV, and has become the most common cause of serious liver infection in the world. Approximately 1.5 million persons are chronically infected with HBV in the United States. More than 150,000 Americans are expected to die from Viral Hepatitis associated with liver cancer or end stage liver disease in the next decade.

Hepatitis C is most efficiently transmitted through contact with blood through

injection drug use. Hepatitis B can be transmitted by blood or other body fluids, through direct blood contact, sexual contact, and injection drug uses, and from an infected mother to her fetus or infant. Both Hepatitis C and B disproportionately affect minorities. Hepatitis C infection is complicated by the presence of sexually transmitted infections and also disproportionately affects persons who engage in high-risk unprotected sexual activity. Persons living in poverty and those men who have sex with men. There is evidence, too, that it may disproportionately affect transgender persons. All of these groups also have less access to care. In particular, African-Americans and Hispanics are affected by Hepatitis C, and Asian and African immigrants are affected more by Hepatitis B. These disparities are of particular concern to HHC given our focus on reducing disparities and eliminating barriers to care.

The Centers for Disease Control and Prevention, DCP, estimates that although Americans born between 1945 and 1965 comprise and estimated 27% of the population, they account for approximately 75% of all Hepatitis C infections in the United States.

Seventy-three percent of HCV associated mortality, and they are the greatest risk for developing Hepatocellular Carcinoma and other HCV related liver diseases. While the recommendation to offer once-in-a-lifetime screening and follow-up on this population is of most concern to address, there is recognition that some adolescents may also be of significant risk of HCV, especially those who are starting to inject drugs.

An estimated 146,500 New Yorkers are infected with HCV, but less than half may be aware of their infection. People who were born between 1945 and 1965 have a higher prevalence of HCV infection. In the past, treatment for HCV infection was long, fraught with severe side effects, and not very effective. In addition, individuals who were tested with traditional laboratory tests often never receive or return their results, or even many HCV infected persons are unaware that they are infected.

Recent advances of rapid HCV diagnostics and HCV medications have changed the landscape of HCV treatment because current treatments have significantly hire cure rates at 95 to 100% in clinical trials. They have a much shorter treatment

period and have fewer side effects. Rapid HCV screening technology and better treatment options provide a tremendous opportunity for improving health, saving lives, and reducing health disparities. With this easy testing and better tolerated treatment, it is anticipated that more patients will complete treatment or avoid the most pernicious aspects of HCV infection. There is also a safe and effective vaccine to protect against Hepatitis B infection, and it is recommended that all infants, children, and adolescents up to the age of 18 receive the vaccine, as well as adults who are at risk for infection.

HHC is prepared to take advantage of the recent advancements in treatment and diagnosis to build on or modify our service structure, and apply what we have learned addressing the HIV epidemic to reduce the burden of Hepatitis in New York City. With additional resources, HHC could collaborate with the OHMH, community-based organizations, and other stakeholders as well as pharmaceutical and diagnostic testing companies to create an infection response program that would:

1. Expand testing for persons with HCV and HBV infection, and educate and link them to care and treatment.

2. Educate providers and increase treatment capacity through telemedicine, expert consultation, and involvement of our patients.

3. Monitor disease patterns and response to interventions.

4. Share our results with others interested in these issues, and

5. Design and implement a media campaign to educate the public about HCV and HBV, and provide an infrastructure for coordination of care, case management, and medical adherence support.

HHC is committed to improving patient outcomes by delivering comprehensive, high quality medical care and supportive services to patients with Hepatitis C or Hepatitis B. With commitment over time, new innovations in testing and treatment interventions, we are hopeful that we can make great strides in reducing the transmission and burden of these diseases in New York City. This concludes my testimony. I would happy now to answer any questions you may have.

CHAIRPERSON JOHNSON: Thank you very much for testifying today. Thank you again for your hard work on this issue. I have a few questions, and then I'll turn it over to Council Member Chin. I want to just clarify that this bill calls -- Dr. Varma, you mentioned in your testimony, and I want to clarify something that I just think potentially was a misunderstanding in our language in the bill. This bill calls for reporting on new liver cancer diagnoses, not on deaths due to liver cancer. So in terms of what the bill calls for, what might the benefit of this metric be in your mind having to do with cancer diagnoses, not deaths?

DR. JAY VARMA: Thank you. So I think-- So there are two questions inclusive in this. One is if the metric could be measured, what is its value? And then the second question we always ask is can it be measured? So in terms of its value, I think there is definitely tremendous value in monitoring the end-state consequences of Hepatitis B and Healthcare Information Standards infections. And the two most severe consequences are what we call end-stage liver disease where your liver is horribly damaged and can no longer function or liver cancer.

So if you are able to measure liver cancer diagnoses, and also link them to whether it's caused by Hepatitis B or Hepatitis C, both or neither, that is tremendously useful. There is a tremendous value in being able to monitor what the morbidity of these diseases are because then you can get people to care about them more. The challenge, of course, is in measuring those as well. I'll have to confirm. I'm not positive whether all diagnoses are reported to the State. I believe there is a cancer registry that the State maintains.

CHAIRPERSON JOHNSON: [interposing] Yes.

DR. JAY VARMA: We don't maintain that here ourselves.

CHAIRPERSON JOHNSON: I believe that the State Cancer Registry includes liver cancer, yes.

DR. JAY VARMA: It's all liver cancer diagnoses?

CHAIRPERSON JOHNSON: Correct.

DR. JAY VARMA: Okay.

CHAIRPERSON JOHNSON: But, yeah, speak into the mic. Introduce yourself, and then speak into the mic. Thank you.

DR. FABIENNE LARAQUE: Hi, my name is Dr. Fabienne Laraque. Good morning. Liver cancers are reported and primarily by pathology laboratories to the State Cancer Registry. However, we don't know what are their causes or link with Viral Hepatitis because to do so we would have to match the Liver Cancer Registry with the Viral Hepatitis Registry [sic]. But the number of liver cancers reported is easily knowable, and it's a valuable consideration.

CHAIRPERSON JOHNSON: Thank you very much. Dr. Varma, why do you think-- What do you think the reason is for the 46% increase in the annual HCV death rate over the last 15 years?

DR. JAY VARMA: The virus Hepatitis C behaves differently than some other viruses. With, for example, HIV infection there's period anywhere from five to ten years between the time that you're infected, and the time that you develop severe or obvious symptoms of the disease. With Hepatitis C, that period, what we call sort of the latency period between the time that you first are infected, and the time that you start to develop very obvious consequences of disease. It can be 10, 15, or 20 years. So we think that what we are seeing now in

terms of rising deaths from Hepatitis C are not new infections, but rather infections that occurred 10, 15, 20 years ago, and are now producing severe consequences of that infection. We know that Hepatitis C infections across the United States peaked sometime in the late '80s or early '90s. So it was predictable that 20 something years later we would see this increase in deaths.

CHAIRPERSON JOHNSON: I apologize for jumping around between both diseases because I know that they are unique. If you could explain why although the incidents of new Hep B infections is low recorded at a little over 8,000 unique infections newly reported for HBV in 2012, why do you think it is so low?

DR. JAY VARMA: Why do we think it's low compared with for Hepatitis B? I'm trying to clarify exactly. I wouldn't say 8,000 is low. I mean I think what we're actually surprised at is that there are that many infections, of course. Hepatitis B, as we know, is a vaccine preventable disease. So if the United States had essentially closed borders, we would expect that over time there would be no new infections. But, in fact, like other diseases that

we see in New York City, we reflect sort of the global population of diseases. So the vast majority of those diagnoses occur in people who are not born in the United States, but rather immigrated here with that infection.

CHAIRPERSON JOHNSON: I'm going to have more questions later on, but I'm want to turn it over to Council Member Chin, who is the prime sponsor of this bill.

COUNCIL MEMBER CHIN: Thank you, Chair. I your testimony you talked about I guess in 2012, you were able to do this what do you call the CDC Grant to do this report. So what happened when the grant ran out? Did you still continue to collect data, and what kind of resources do you use to continue to do that?

DR. JAY VARMA: Great. Thank you for the question, and thank you for your interest in this disease. So, just some brief background is that a lot of our infectious disease work is funded by the federal government. Unfortunately, as time has gone on, we've become increasingly dependent on federal government grants. Which makes it challenging when there are periods when CDC either cuts grants

completely, or when it recomputes those, and decides to go in a different direction. In this situation in 2012, CDC recomputed this grant and we along with several other jurisdictions around the country were not funded again. So at that time we lost seven -- we lost funding for seven full-time staff. Because we have a tremendous interest in trying to continue to collect valuable data about this disease as well as to design other programs to help treat it, I've essentially spent a lot of effort trying to work on different ways of reapportioning staff time so that we can continue to collect this data.

So right now we have in total I would estimate 34 staff in our department who work in some way on Viral Hepatitis. That includes Hepatitis B and Hepatitis C. The majority of those staff, 24 of them, are fully funded by a CDC grant to prevent perinatal transmission of Hepatitis B. That is transmission from mother to child. It's this intensive case management we do for about 1,800 pregnant women every year. The remaining ten staff are dedicated to making sure that we receive reports. We call deduplicate them, which is make sure there aren't two people being reported by two different

sources, and then, of course, try to analyze that data. And that's the data that we have spent time trying to make sure it's publicly available on the Internet. But we have not, in fact, had the staff resources to put together a consolidated report.

COUNCIL MEMBER CHIN: So what kind of information data or metrics relating to both Hep B and C are most critical for you to collect so that you can raise awareness about this disease?

DR. JAY VARMA: I think that the items that are included in the proposed legislation are all tremendously valuable. The challenge that we have raised is that some of them are difficult to measure simply because of the science and biology of the disease. For example, acute infection. That means somebody recently infected with the diseases. Most adults either with Hepatitis B or Hepatitis C infection do not develop enough symptoms to prompt infection and go to the doctor. So that's why measuring some of these metrics like acute Hepatitis B and C while it would be wonderful to know about because it would give us a very real indication of how well our prevention is work, even though they're

very valuable, they're almost impossible to measure accurate.

And some of the other metrics that are proposed again they're highly valuable, but they do require a tremendous amount of time and effort to produce high quality versions of them. So, for example, we could readily collect through New York State data about deaths from -- I'm sorry, diagnoses from liver cancer. But that doesn't tell us, as Dr. Laraque mentioned, how many of those are directly attributable to Viral Hepatitis. They could be due to any of a number of other causes. So to get really accurate data, what we need to do is link together the data from the cancer diagnoses to the data that we have already collect about people with Hepatitis B and Hepatitis C. And while we do have computers, and advanced software, all of this really does require person hours, and that's really one of the biggest challenges that we face is having enough staff and time dedicated to working and getting high quality data.

COUNCIL MEMBER CHIN: So what is the projection of the costs that you're looking at, the ideal situation in terms of being able to collect

data that are crucial, and also data that the Department lacks right now?

DR. JAY VARMA: Yeah, so our Intergovernmental staff I think we can provide a detailed budget to your staff to go over that. We estimate that purely for staff time alone we would need somewhere between one to one and a half million dollars to be able to have enough staff to collect all of the data with the highest quality possible. On top of that, ideally to meet the efforts needed in here, we would need a lot more than that, of course, because there is money that would be needed for vaccinations, for screening tests, for training activities. And so, we have different budgets that we've prepared, and we'd be happy to share with you different models of scale. One is just collecting data, and the other are actually implementing services that we know are needed for these diseases.

COUNCIL MEMBER CHIN: That's a lot of money. I mean, when you're talking about that kind of money, I mean I would rather see in some way that kind of budget going towards actually care and saving lives. So there's got to be a way to sort come together on that. That data that is easily collected

or that you have right now, and do we sort of be able to put those data together? And really use it to advocate, and also to build awareness? I mean this has been going on for a long time, and even for the City Council the frustration is that it's taken us five years to even get some attention on this bill. And we've been trying to fight for an initiative that would offer testing, education and referral to care.

And hopefully in this budget we're going to get that going. But it is something that is so critical, and at the same time I know that what we hear is a lot of drug companies especially because Hepatitis C there is a cure. So the drug companies are making money, and they are -- And they should do more in terms of helping with the testing and rather than asking government to sort of put in a match or whatever. And that's what we've been hearing out there. So I mean in your expertise, I mean how can we really tackle this problem of growing Hepatitis B and C in our community? What is the best, most effective way to bring about awareness and get people to start coming forward and get care, and hopefully we can save money in the long run, if they're getting treated earlier?

DR. JAY VARMA: No, I think all the points you raised are very challenging and important questions that need to be answered. Let me talk about three things quickly. First is the magnitude of the cost it might take to collect good data, and whether that's worth it. And then try to answer specifically your two questions about Hepatitis B and C since the efforts are a little bit different in terms of what I think is needed. First as it relates to cost. In the grand scheme of things it's not a lot of money, and the reason I say that is because there is one thing that health department can do that no one else can do. And by no one else I mean nobody in the private sector, nobody in other city agencies can do, and that is produce highly credible data about the burden and incidents of specific health conditions.

The number one most important thing that a health department can do is track why people are dying. Or if they are dying, what they are dying from, as well as hopefully infections and other disease processes that occur. And the cost of doing that is expensive. You need highly trained staff to be able to gather this information, to interpret it

correctly, and present it in a way that's intelligible to other people. And that's not something that you can document as simply as -- that you can document simply because reports come in, and the computer spits them out. So I would say that compared to many other diseases that are much more well funded, this disease that is rising in incidents is one that does merit that type of investment.

Now in terms of the interventions that will be most effective, they are different for Hepatitis C versus Hepatitis B because of where we are at with the technology that's essentially available to cure people. For Hepatitis C, really what we have is a disease that has now become curable, but the majority of people who have this infection don't know that they're infected. And many of the doctors who have trained in the past are not aware of how quite easy it is to come, in fact, to manage and treat these patients.

So really what we believe would be most effective are awareness and training programs dedicated to make sure that healthcare providers know how to test patients, test them accurately, and then offer them care. Where the place that we were

similar to say HIV infection in the mid '90s when new drug regimens were coming out every six months to every year, and it took a long time to build up the technical expertise to do that. Related to that is awareness of the public, but as you mentioned the pharmaceutical companies have a vested interest in this. So we expect that a lot of public awareness isn't nearly as necessary simply because there are other people with a financial interest in doing that.

Hepatitis B is much more challenging, and one the one hand it should be a disease that's much more easy to manage because we have a highly effective and safe vaccine. The challenge, of course, is that we are being -- we are very successful at preventing new infections among people born and raised in the United States. But where the health disparity exists is in people who immigrate to this country and are already infected. And unfortunately, the technology is not there for there to be a readily available and simple regimen that will cure this disease. So for Hepatitis B, a lot of our interventions, as you mentioned, really should be based on raising the awareness both in the community and of providers to screen for this infection. And

then to offer whatever services are potentially available to help reduce the consequences. Sometimes they may be just educating people about how to keep their liver healthy. Things like abstaining from alcohol, getting vaccinations against Hepatitis A, which can also cause problems. Related to that might be screening for cancer in selected groups. And then in those whom there are, the health resources available through HHC or community organizations to provide treatment when necessary to help reduce the severe consequences of that infection.

COUNCIL MEMBER CHIN: I think your first point about a highly credible data report. I mean I agree with you. I mean we want to be able to do that, but that is something that I think we really need to continue to look towards our federal government to really help us, and just, you know, the grant money. This is an important health issue in our city. So I think we have to work with the Mayor and our federal elected officials to really advocate on that. And also, I think with this whole awareness and training. I think my question, and I'll turn it back to the chair is that how do you see working with community organizations, community-based providers in

sort of providing these kind of education and awareness. It comes down to also an issue of funding. Because they're the ones that really is on the ground and working with the immigrant community in dealing with those issues. So how do you see the collaboration, and what would be the most effective way of really bringing all the groups together?

DR. JAY VARMA: I think that you're absolutely correct that the groups that are, the clinical facilities, the health deliver organizations that are based in these communities are the ones who are best prepared to deliver these services. And they are absolutely critical partners for everything that we do. One of the things that we have done through the department with the limited resources we have is we have one city-funded person full time who works on building these coalitions. So we have a task force related to Hepatitis C and a coalition related to Hepatitis B to bring people together to talk about the resources they need to exchange technical information with each other and to train each other.

Of course, to really make an impact, we also, of course, want to dedicate resources to help

support those organizations. And I do think the Health Department can play an important role along specifically with the expertise at HHC in providing mentorship and guidance and monitoring. To make sure that any money that does go to this organization through a fund whether it's in City Council, whether it's in the Executive Budget, is spent in a way that really is benefitting the community in the best possible way.

COUNCIL MEMBER CHIN: Thank you. I'll turn it back to the Chair for now. Thank you.

CHAIRPERSON JOHNSON: We've been joined by Council Member Cornegy. Thank you for being here, and before I go to Council Member Arroyo, I just want to -- We are joined by -- I didn't see her sitting down there -- Council Member Mendez as well is here. Thank you, Rosie, for being here. I want to just establish, which I think we are in agreement on this, that the intention of this bill -- And I know we always have to consider the financial impact, and the time and cost it's going to take to implement these things. But the thrust and aim of this bill is to achieve good things that you would support if you had the money to do so. Is that correct?

DR. JAY VARMA: So the indicators that are listed in these bills on reporting around Hep B and C you find them to be valuable things?

DR. JAY VARMA: We have some specific critiques. I don't know if we need to go into them here, but we've talked with your counsel about how things are worded. There was some challenging wording around them. But the intent behind all of them is we're in agreement with. It's just that for some of them, as we mentioned before, we would prefer the wording was changed so that it was a more accurate reflection of what we could actually apply. [sic]

CHAIRPERSON JOHNSON: I mean I want to really defer to Council Member Chin on what ends up happening with this bill along the lines of the funding that's required to actually implement this in a way that works for DOHMH. But I would just say that given that I think there is broad agreement that what is proposed in this bill is valuable, and will be helpful public health related matters for Hep B and C. That hopefully we can work with the Department after looking at the proposed budgets that you put forward on this, and potentially come up with

some other ways. Is it not annual reporting, but annual -- but reporting every two years, every three years. Are there other ways that we could seek to start to look at some of the most important metrics, which Council Member Chin asked about? So I'm hopeful that given that there is agreement that this is good, we can then work together to figure out how we can best execute this and implement this. And I want to turn it over to Council Member Arroyo for her questions.

COUNCIL MEMBER ARROYO: Thank you, Mr. Chair. Dr. Varma. I don't know that I would want to work for you and two of your staff sitting here. I want to embrace this.

DR. JAY VARMA: My fault. [laughs]

COUNCIL MEMBER ARROYO: On a serious note, the CDC grant, what was the amount of the grant?

DR. JAY VARMA: I'll check with --

[Pause]

DR. JAY VARMA: About $5 million. We can get you the exact number, though.

COUNCIL MEMBER ARROYO: So, have you asked the administration for the money to continue the surveillance monitoring?

DR. JAY VARMA: [interposing] Yes.

COUNCIL MEMBER ARROYO: And what happened?

DR. JAY VARMA: We haven't gotten it.

COUNCIL MEMBER ARROYO: And have you talked to anyone in the City Council about your desire to get funding for the surveillance activity? And whether or not we could be helpful with that advocacy with the Administration so that the agency could get funded by the Mayor, not the City Council?

DR. JAY VARMA: I'm sorry, yes there has been a lot of discussion I know with Council Member Johnson's staff and with other members of Council, and with the City Council as well in trying to mobilize resources both for surveillance activities, as well as for services in the community.

COUNCIL MEMBER ARROYO: And I would imagine the advocates in the community have heard that same desire from the agency. Because I haven't heard from any of them about you wanting additional money for this, and they are not quiet.

DR. JAY VARMA: Well, but I think, of course, there's always a -- the organization that is being asked is the one that's always going to know most about what it needs specifically. There are tremendous needs for this disease obviously in every part of the health system whether it's the Department of Health or whether it's a community organization. So I can't speak on behalf the community organization, but if I was coming from a community organization, one of these committees, I would be focused on advocating for resources for my program for than anything.

COUNCIL MEMBER ARROYO: Not necessarily. I think that we've done a lot of work with community-based organizations and advocates around strengthening the funding for agencies so they can do good work better. And I recall a hearing that we had in the Health Committee where we discussed why Hep C and Hepatitis data is not readily available in the same manner that HIV and AIDS surveillance data is available. I think I recall making a statement to the effect that I think the New York City Department of Health probably has the best surveillance data on HIV and AIDS probably nationally. And that started

from nothing, and now it's I believe a model for how data should be reported, and the frequency of it. What is your commitment to making that possible for Hepatitis? That was the question I was asked.

DR. JAY VARMA: Yeah. No, absolutely. I think that if there was a way for us to collect data, as we do with HIV with that same high quality, that is absolutely what our goal would be. In fact, one of the reasons we have amended the Health Code, the work at the Board of Health to amend the Health Code was so that we can start to collect data specifically for Hepatitis C similar to the way that we collected for HIV. Hepatitis B is a little bit different. The science of it is different such that you couldn't monitor it in quite the same way. Again, just to emphasize this point, the reason New York City has such an incredible surveillance for HIV is because we also have more than $5 million a year that we get from CDC that specifically funds surveillance and prevention activities. So it's not--

COUNCIL MEMBER ARROYO: [interposing] So on your own--

DR. JAY VARMA: -- it's not something that could be done really--

COUNCIL MEMBER ARROYO: On your own you would not be able to? Without that grant, you would not be able to have that incredible database?

DR. JAY VARMA: Absolutely. Correct.

COUNCIL MEMBER ARROYO: So, HHC, since you're here, we may as well make you sweat, too. Your testimony, though, references that with additional resources you could do, and you listed five different things. But the resources you can collaborate with DOHMH, community-based organizations, stakeholders, pharmaceutical companies, diagnostic and testing companies to create an infection response program that would, and you list the five. So how much would that cost?

DR. JOSEPH MASCI: Well, that's hard to say with any certainty. We have a huge catch-up that has to take place in medical care.

COUNCIL MEMBER ARROYO: You have a huge ... ?

DR. JOSEPH MASCI: A huge catch-up phase that has to take place now in medical care for Hepatitis B and C and particularly C. Now that there is routinized testing for Hepatitis C, and we're seeing more and more people coming into care. So,

you know, the comparison has been drawn with HIV in the mid '90s. And I think there is some validity for sure, but there's also a difference. By the mid 1990s in HIV care we had designed AIDS centers. We had sophisticated programs all over the city that were ready to adopt any changes in treatment as they came along and quickly implement them.

That's not the case with Hepatitis B or C. What we have across the city in the hospital system, and I Chair the Chiefs of Medicine Committee for HHC, is a varying degree of resources that have been devoted to this traditionally up until now. So in some of our facilities Hepatitis has been handled primarily in the HIV clinics among co-infected patients. And some of the facilities have been held primarily in the gastroenterology clinics, primarily not co-infected patients. So what we need to do is put together a system within healthcare that allows for easy identification of infected people in a very convenient user-friendly system for them to come into care and be evaluated.

Because not everybody requires treatment, and certainly not everybody requires treatment immediately. To try to triage those patients who do

-- would benefit from treatment soon, all of this requires a substantial degree of expertise. Yes, Hepatitis C has become largely curable, but it's been handled primarily by people ho are quite skilled and expert in its treatment. And when something is curable with brand new drugs, that's going to continue to be a requirement that people are going to have to be somewhat expert in that.

COUNCIL MEMBER ARROYO: Okay, is there a national model that we can look at?

DR. JOSEPH MASCI: Not really. There isn't. There are systems -- there are centers of excellence, if you will, in Hepatitis C including some in New York City where they have had a long history of clinical research and treatment of Hepatitis C. But there are not very many of them at all, and I think nationally there is a genuine shortage of providers for Hepatitis C care.

COUNCIL MEMBER ARROYO: So could you tell the Committee now today, we've got some smart people in HHC and DOH, what HHC would need in order to create this model that you've described in your testimony?

DR. JOSEPH MASCI: Sure, and let me just add that this would not be feasible as a totally self-contained HHC model. This would require collaboration with DOH and the systems. One thing we've talked about several times is setting up a telephone consultation system among experts within the city to manage these patients. And just speaking as a provider, these diseases can be quite complex to treat, actually. Even someone who is successfully treated for Hepatitis C, that means they first have to be evaluated for about six months to see if they actually have active Hepatitis. Then a decision has to be made about the degree of liver damage. So we can decide how urgent treatment is. Then treatment takes place. It can be anywhere from three to 24 months, and then a period of observation after that to ensure that they have actually been cured.

COUNCIL MEMBER ARROYO: But Dr. Masci, you wrote the testimony.

DR. JOSEPH MASCI: Yes.

COUNCIL MEMBER ARROYO: You're the one that said that with additional resources you could do X, Y, and Z, and all I'm asking is if you can provide to the Committee what that would be in order for

there to be a more comprehensive conversation not just around surveillance. But also the education and prevention providers need to be brought up to speed, and better prepared to handle the cases. That's all I'm asking.

DR. JOSEPH MASCI: Absolutely.

COUNCIL MEMBER ARROYO: [interposing] I'm not debating you.

DR. JOSEPH MASCI: I know you're not, and I appreciate--

COUNCIL MEMBER ARROYO: [interposing] I'm not debating you at all.

DR. JOSEPH MASCI: --to talk about this. We're very passionate about it. I just want to give the Council Members a sense of the magnitude of what we're facing.

COUNCIL MEMBER ARROYO: We get it. Thank you, Mr. Chair.

CHAIRPERSON JOHNSON: Thank you Council Member Arroyo. I mean I should have, I guess, said this before. I really do applaud DOHMH's and HHC's valiant, I think thoughtful and real efforts on setting up programs, as you listed, Dr. Varma, that have been implemented and carried out to try to do

work on this. I would just say, and I as a new member of this Council, I say this taking responsibility as well. That we know that when there is the political will and resources dedicated to something that we have an answer for, which we do on Hep B and C by and large, that we can really do significant work to reduce new infections and protect people.

Not to talk about history, but we saw what happened when real resources were dedicated to HIV and AIDS, after it had been ignored for many, many years, and resources weren't dedicated in a real way. And this disease, these diseases I think fall in line with what Dr. Bassett spoke about so passionately when she was announced as the new head of the Health Department and all of her testimony before us which is trying to combat disparities in communities across the city. And we see that this disproportionately are affecting people of color, people of Asian descent, people of African descent. This affects transgender people. This affects people that are mostly poor, and are not having proper access to healthcare in a real way with preventive medicine, primary medicine.

So I say that we really have to redouble our efforts. I'm not sure that Hep B and C have gotten its real due share of attention as it relates to the media and people organizing around this in the same way. I know that there are coalitions that have been set up, and networks. And I don't say that in any way to take away from the incredible work that the advocates have done, and the department has done. But I think that it is time given what we are seeing. I mean the number is devastating that I read to you earlier. I know it has to do with the Baby Boomers and coming of age and all of that. But, you know, a 46% increase in the annual death rate over the past 15 years, that is like devastating. And in many ways it's an indictment on us not doing more.

I know we've done some, but us not doing more, and dedicating more resources to this. So I am hopeful that there will be some money in this budget, that we've worked so hard on, dedicated to doing some work on Hep B and C. We will see what that is, but I'm hopeful that something will happen on that. But I would say that as Chair of this Committee I feel like I have to do more over the next year to make sure that when we start to have these conversations

with the Administration, and with our partners at the federal and state level, that we get adequate resources. So that the Department of Health and Mental Hygiene isn't reliant upon a federal grant to carry out important data gather, and other valuable public health goals on this.

On that measure, I want to ask about -- I know that in 2008 and 2009, DOHMH did surveillance reports on Hep A, B, and C. I wanted to understand if the reason why there hasn't been further reports done since 2009 over the last five years, if that has to do with the loss of the CDC money. Why haven't there been other reports done? Does it cost a significant amount of money to produce those reports? I want to understand what the benefits actually were of having that report. And what changes in programs and initiatives developed from having that report? Once you had that information, what was done when you had that to chance what your efforts were at DOHMH?

DR. JAY VARMA: Thank you. Just to reiterate, I greatly appreciate, Council Member Johnson, all of your concern about this disease. It's something that we care a lot about. We don't come asking for money because we want more staff to

feel more powerful, we know there's a need out there, and we want to do the best that we can to address it. To answer your question, yes specifically the report it's not the printing costs that's the challenge. It's the human hours that are spent preparing something, adding it, formatting it, getting into a form that's necessary. And so that's really why we, when we lost the CDC grant, we didn't dedicate staff time to producing other paper report.

What we did do is I did find money to help support, and so we wouldn't actually lose many of these staff. To find other sources of funding for them to continue to allocate some of their time to working on this. And then we dedicated our attention to trying to make sure this data was available in this EpiQuery system, which is available online. And that's not a simple process because we have to make sure that the data is clean in such a way that it won't be -- some of it can't be re-identified, and that it could be analyzed in a user friend way. So we did dedicate resources to making sure it was available on the assumption that if people want data, now it's readily available.

It's now in a physical copy. What is the advantage to a printed report? I think that it depends on how you look at it. I think from the perspective of people having access to data, I think having it on the web is as good as anything else. In terms of having something tangible that you can present whether it's to a policymaker or to a funder, or to educate physicians. there is tremendous value in having something printed and compiled. It's just that when we have to allocate resources in one direction or another our general interest, at least my motivation now is to make data publicly available in the most user-friendly accessible way possible. And then if there are additional resources to then go ahead and make it available in a printed format. In which case it's maybe more user-friendly to -- for the purpose of advocacy.

CHAIRPERSON JOHNSON: So what program -- what changes occurred, if there were any, from actually compiling that information and putting it into a report, how did that influence the Department after the report was put together?

DR. JAY VARMA: Yeah. I wouldn't say that it probably changed anything that we actually

did because we try to dedicate resources to analyzing that data, interpreting it, and using it for work. And so, producing the report while it helps, it a collaborative process inside our organization that helps everybody become aware of the data. I wouldn't say it has a tremendous impact on how we do or change our policies. Because often times we're analyzing the same data to present at scientific conferences, or community meetings. I would like to use an example, though, of how we use our data for programming, and to highlight an issue that I haven't adequately had time to address during this.

Which is that the data that we have related to Hepatitis C does indicate that though the vast majority of infections are those that are already out there. What we call prevalent infections, people infected 15, 20, 30 years ago. We are concerned about increases in Hepatitis C infections in specific populations. And I'm referring specifically to people who are newly injecting drugs. I think everybody in the community is very well aware about the epidemic of prescription opiate use, and how it has spread through all parts

of the city. And that, of course, is then leading people to transition to injection drug use.

And the people that are using injection drugs now, that are initiating for the first time are often much less aware of the syringe exchange services that the Council has been a tremendous advocate for. And it's a tremendous public health success story that's led by the Council. And so, we are concerned because we have seen and analyzed for Hepatitis C data to see that the rates of infections are rising among people between the ages of 20 and 30. And we have looked at those infections, and of the cases that we interviewed, a number of them report having used injection drugs.

So we know that these injections are attributable to injection drugs, and they're occurring in areas where you also see high rates of overdoses as well. So there clearly is an overlap between these epidemics. And that's an example of how the data that we collect can help us on a year-to-year basis really move and advocate in ways that are better. And so, we work very closely with our colleagues in Mental Hygiene. And I know we've discussed with people in the Council about trying to

dedicated more resources for syringe exchange programs and Viral Hepatitis prevention programs within those exchange programs to address that problem.

CHAIRPERSON JOHNSON: To follow up on new infections as it relates to Hepatitis C and injection drug use, do we have demographic information, reliable demographic information on what that population is? Does it span ethnicity and race? I know you said that ages we're seeing infections among people who are between 20 and 30 years old. It would be helpful to understand distinctly the populations where we're seeing the increase in both through race, and also through geography?

DR. JAY VARMA: Chairman, do you want to --

[Pause]

DR. FABIENNE LARAQUE: Yes, we are fortunate enough to actually have a fellow from the federal government, who is unfortunately leaving, but he has been working and looking at this issue. And what we are able to do is interview everyone reported below the age of 25, and half of those reported between the ages of 25 and 30. And ask about their

providers, and then questions. What we know is that those individuals are throughout the city, but there's a lot of them on Staten Island. From the point of view of race and ethnicity, there is about third White, a third Asian, and a third African-American. And another interesting fact is that's been reported as your socio-economic status. [sic] It's actually pretty well distributed throughout socio-economic status as opposed to the more adult older Baby Boomers into ways with Hepatitis C. [sic] So what we see in the younger population is actually quite different.

DR. JAY VARMA: We have a manuscript as well as a presentation about this that we would be happy to share with the Council that describes it, and it also describes the neighborhood specifically.

CHAIRPERSON JOHNSON: Thank you. I have a question for Dr. Masci, what do you see day-to-day at Elmhurst Hospital in terms of challenges, treatments, trends that would inform our discussion here today?

DR. JOSEPH MASCI: In the area of screening, since January screening has stepped up quite a bit in our primary care clinic, and our

emergency department, et cetera. So we're seeing an influx of newly identified Hepatitis C patients. And what we've done there is we have created a joint infectious disease GI Clinic staff by our interns and fellows to begin to evaluate those patient. What we expect is a rising trend of increasing numbers of patients coming to us now on a regular basis with Hepatitis C. Hepatitis B it's been a different situation. As Dr. Varma pointed out, there is a new testing initiative, but we are following a large number of patients with Hepatitis B. I think 200 are currently being treated in our Hepatitis GI Clinic. That is more of a steady state. Obviously, we have an interest in reaching out to the community to identify more patients that way. But it has to come hand-in-hand with the process as I was describing here to bring them into care appropriately. As far as the medications, the cost of the medications is extremely high. Medicaid covers them so far. So patients without insurance, of course, don't have coverage. ADAP depending on what version of ADAP the person has for the co-infected patients, may or may not cover all or part of the medications for Hepatitis B.

So what we're seeing is kind of a merging of resources that were already there handling HIV related issues into this new strategy to approach Hepatitis B and C, particularly C. What we don't have is the additional staff that HIV care brought with it because of the funding. The space obviously the issues a very big. A busy hospital, but we're working on that. We're very eager to take advantage of these new medications, and new testing technologies to really benefit the community and do something. I think people like clinicians and public health experts in this line of work right now see this as a fantastic opportunity to do a world of good if we could just get our systems moving smoothly. Either way, we're doing a lot of good already because the medications have gotten so much better. But we have a great opportunity here.

CHAIRPERSON JOHNSON: Thank you, and I want to just talk a little bit more specifically about the cost of these drugs because it is sort of mind blowing what it costs for 12 weeks of treatment just on Hepatitis C. I believe Gilead and Sovaldi companioned with OCO, and the cost of that over the course of 12 weeks in somewhere in the range of

$140,000 for the course of the treatment. But it has a 98% success rate. So if there was more availability, testing done so people knew that they had the disease, we could actually really make a dent on this. Again, I think that shows why the government needs to focus more on getting people test, and then linking them to care to take care of this so we don't see a further spread of this.

I have some more questions for the Administration for DOHMH. We know as Council Member Chin and Council Member Koo mentioned that those of Asian descent comprise nearly three-quarters of the infected worldwide, and half of the afflicted population in the United States. Does DOHMH provide targeted, culturally sensitive education and services to ensure that high-risk populations such as folks who are of Asian descent are reached in DOHMH's clinical settings? And if you could talk a little bit about those programs, if they do exist.

DR. JAY VARMA: Yeah, I would say that the basic answer is that the only real clinical services that we offer that are related to Viral Hepatitis are in our immunization clinics, our STD clinics. Occasionally in our Tuberculosis clinics,

and in our correctional health system. In our immunization and STD clinics we provide vaccination to people who are eligible. I would say the vast majority of those vaccines probably go to men who have sex with men. Who are one of the groups that's at high risk for HBV and Hepatitis B infection. I don't know the demographics of Asian-Americans that go to our STD clinics. That's something we could look up, but I suspect it's not a huge population in terms of people who are vaccinated because they are an immigrant from a high infected [sic] country.

In terms of our immunization clinics, we do provide Hepatitis B vaccination also in our immunization clinics, and we could also look up the demographics as well related to that. And in our correctional health system, of course, as you know the vast majority of the people in the correctional health system are the Black or Hispanics. So it's not the same population of people that are coming in with Hepatitis B. But we do provide both vaccinations in the correctional health system, as well as diagnosis, and occasionally treatment for Hepatitis C infections there.

We also do produce a number of different educational materials related to Hepatitis B, which is I think most of what your question is related to that are linguistic, and we believe culturally appropriate. We mail those brochures to anybody newly diagnosed and reported to us with Hepatitis B. And specifically for that population that we manage closely, about approximately 1,800 pregnant women every year, the majority of whom are Asian-American. We also provide intensive education to them and, of course, to their providers to reduce the risk of transmission to their children and other family members.

CHAIRPERSON JOHNSON: And the materials that are sent out, in how many languages are those sent out? Is it just in English?

DR. JAY VARMA: I'm being told it's English, Spanish, and Chinese.

CHAIRPERSON JOHNSON: And Chinese, and when education is being done for pregnant women who have been infected, and are being connected to care, if they are of Asian descent, and English is not their first language, are the receiving services from people that speak their primary language?

DR. JAY VARMA: Yes, we have a number of -- in fact the majority of our staff that work in what's called our Perinatal Hepatitis B Program speak Mandarin, speak Cantonese, and let me pause for a second.

[Pause]

DR. JAY VARMA: Okay, we'd have to follow up on other dialects that are spoken.

CHAIRPERSON JOHNSON: Okay, and those who are at chronic HCV risk, as you mentioned African-Americans, people infected with HIV, people who inject drugs, children born to mother with HCV, people with sexual partners who have HCV, people with tattoos or piercings, the transgender population. How does DOHMH currently reach those populations?

DR. JAY VARMA: So as I mentioned, most of the work that we do related to Hepatitis C has been in developing educational materials or information that can then be distributed by other providers. But we don't have, to be honest, we don't have large scale campaigns dedicated to educating people at risk. It's expensive to launch big multi-media campaign. We have developed, as I mentioned, smaller initiatives. We have a public service

announcement. We have an app. We're modifying our we pages, and we work very closely with our community partners through our task force to try to distribute this information so that they can then go on and distribute to clients of theirs who are potentially at risk. But there is absolutely a need for us to do more in terms of getting information directly in people's hands as opposed through always working through intermediaries, or through these potentially less effective and less crowd reaching measures.

CHAIRPERSON JOHNSON: Does the Department anticipate translating HBV materials in any African languages given that we've seen a high incidents rate amongst immigrants from Africa? For example, French or any other dialects that are among that population?

DR. JAY VARMA: I'll have to look into whether we have or have not done it, and if we haven't and it's a need, then I would absolutely be in favor of doing it. And we'll find the resources to do it.

CHAIRPERSON JOHNSON: I would just say my previous question about reaching these populations that are at risk, people with HIV and people with piercings, tattoos, the transgender community,

injection drug users. I mean I would imagine that it's not easy to potential reach those at risk, high risk populations. And that the potential strategies for reaching them is a little more complicated, and has to be thought out in a potentially much more strategic way. I say that because I don't know if a public service announcement is the most targeted way to reach that population. Is there a way, and maybe it's already done through the coalition that exists, to work with community-based organizations that have daily, weekly, monthly interactions with people that are amongst these high-risk populations and doing something dedicated with those community-based organizations to actually reach these groups. I mean I think public service announcements are great on some of these issues like getting people enrolled for Universal Pre-K. That's a great thing to do a PSA on. When you are talking about very distinct small at-risk populations, I don't know if PSAs are the best way to reach those groups.

DR. JAY VARMA: No, absolutely I would understand. I would say that as it relates to Hepatitis C, first of all just to emphasize, the vast majority of the people that we want to reach are

those in the Baby Boomer cohort. That's where you're going to get the biggest bang. And that's why CDC changed its previous testing recommendations testing, which were based upon identifying people with certain risk factors to a much broader approach. And that's because many people who come to their healthcare providers are not going to disclose their history of having used injection drugs even once in their life, or discuss their sexual histories or history other potential risk factors. So I think the majority of our efforts should continue to be targeted at Baby Boomers. That's one point, but related to that, absolutely is this question about other populations who are at risk, who also deserve as much as anybody else does to know that they're at risk. And to take an opportunity to improve their health. One of the things that I've done is try to actually incorporate Hepatitis C work into the work we have for the HIV Programs. Our HIV Programs that we fund, though they're largely targeted at people living with HIV, they also tend to serve clients of other groups at risk for HIV such as MSM or transgender women. And so, in those programs we now offer, for example, Hepatitis C testing as part of our partner services

for people with HIV. So instead of just testing their partners with HIV, we also are now looking at offering Hepatitis C testing. And also making sure that our providers are required to offer Hepatitis C testing to people at risk as well, too, as part of their contract. So that's one way that we're trying to make inroads into this. And you're absolutely correct that the education that goes to certain groups needs to be highly tailored to them. And a broad media campaign is not going to change that. [sic]

CHAIRPERSON JOHNSON: That's great with those efforts. I understand that DOHMH has developed a public health detailing strategy, which is a primary care provider outreach initiative modeled after pharmaceutical detailing. And that this tool has been effective in the past in educating providers on a particular specific public health related issue. How would this strategy be helpful in the context of HBV and HCV? And what would the Department need to undertake such an approach?

DR. JAY VARMA: Great. Thank you for the question. That's exactly the type of approach that we would love to have the resources to be able to

implement for. Actually, even just before this committee meeting I was talking to one of our partners from the Charles B. Wang center specifically about this issue. About trying to find funding for some type of initiative to work specifically with providers for the Chinese-American community, most immigrant Chinese. It's a more definable population since I think a lot of people for whom English is not their first language, the preference is to go to a Chinese speaking provider, about looking at ways in which we could do some type of strategy. I think absolutely the changing provider awareness and practices is an important part of work both for Hepatitis B and Hepatitis C. Because we know that for Hepatitis C that people in the Baby Boomer cohort are going to be people that hopefully with universal or progress towards universal healthcare will be seeking out medical attention. So because they're coming into the system, there is an opportunity that they can't be missed. The same may not be true obviously for people in immigrant communities. But we do expect that there is enough contact with the health system that we could make an impact that way.

CHAIRPERSON JOHNSON: Thank you. I have a lot of questions here, which I'm not going to get to. And I appreciate already the amount of time that was spent leading up to this hearing and working with DOHMH on this proposed introduction. And the, I think, really helpful answers that were given on the record here today to the Council on what is currently undertaken by DOHMH and HHC in working tirelessly on this. Again, I just want to reiterate that I really hope that moving forward I know that the will exists within DOHMH to do more on this. Not just with regard to reporting, which is incredibly important to instruct us how we move forward on these serious public health matters. But also, with regard to education, outreach, linkage to care, and the quality of care that people are receiving.

And it's my hope that in this budget, that we are able to dedicate some new resources on Hep B and C. I'm not sure if it's going to be in the way that we are discussing here today. But it will I think at least make a difference for the folks that are on the ground doing this type of work. And again, I would say that since there is agreement on the substance of this bill, that we are hearing

today, that these indicators would be important in educating public health professionals, providers, and people in government on what further can be done on treatment and targeting of these populations. That we work together in a good faith way to try to come up with something that works.

I want to really leave that in many ways to Council Member Chin, since this is her bill, and she has worked on this for years and advocated on this. But I would say that I'm not sure how easy it's going to be to come up with $1 million to $1.5 million given where we are today. That doesn't mean that we can't redouble our efforts next year in next year's budget on fighting for additional resources for DOHMH on this. But if there is a way for us to still get critical helpful data moving forward before next year's budget. And figuring out other ways that this could be report, I think that would be helpful to you, helpful to us, helpful to everyone involved on this. And I know given the amount of work that you all have done on this already, and this has been a focus for the Department for years.

It's not a come lately thing to DOHMH. That it's something that you care deeply about. So

there are many questions that we weren't able to get to today. I mean a lot, but hopefully we'll be able to hear from the providers on some of these. And I would hope that given this is the first time I think in a long time that the Council has had a hearing specifically on Hep B and C that DOHMH will stick around. And listen to the providers and to the Council Members on other concerns in matters that are of importance to this committee. So I want to thank you all for coming today. For working so hard on this, and for moving forward in a good faith manner to figure out the best bill possible we can put forward to be helpful to the Department and to the public here in New York. Thank you.

[Pause]

CHAIRPERSON JOHNSON: We are going to go to our first panel, and first up, and I apologize ahead of time if I do not pronounce your name correctly. Don't take personally. Henry Pollack from the NYU School of Medicine will be on the first panel. Mr. Ponni Perumalswami from the Empire Liver Foundation and Center for the Study of Hepatitis C. Oh, Mrs. I apologize. And Dr. Vivian Huang from the Charles B. Wang Community Health Center.

[Pause]

CHAIRPERSON JOHNSON: So thank you all for being here. You may testify in whatever order that you see fit. But before we get to your testimony, if you would all 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? Thank you very much. Who would like to start?

[Pause]

CHAIRPERSON JOHNSON: Great. Please introduc yourself.

HENRY POLLACK: My name is Dr. Henry Pollack. I'm Associate Professor of Pediatrics in the Division of Pediatric Infectious Disesases at NY School of Medicine, and the Director of Pediatric Viral Hepatitis Clinic at Bellevue Hospital. So I want to thank the Committee for inviting me to testify. Viral Hepatitis has been a major part of my professional career. I've been involved with it for probably 15 or 20 years. I was one of the principal investigators of the Asian-American Hepatitis B Program, which was funded by the City Council from

2004 to 2008. And it was the first of the largest comprehensive education, screening, and treatment program for Hepatitis B infection in the U.S. It had a very large impact on awareness throughout the country. As part of that program, in 2008, we had worked with Councilman Allen Gerson, who was from District 1, to propose an amendment similar to the current amendment to the Administrative Code. But it was limited to just Hepatitis B, and as part of that -- And that actual amendment never go through the Health Committee. So I applaud the Health Committee in actually bringing this up to discussion. At that time, and I want to give a little perspective from the years I've been working on this, and with the Council, and with the City with the Department of Health. At that point there was a lot of resistance from the Department of Health because they felt that they did not have the funds to do the -- to be able to respond and provide the data. Subsequently, I was one of the PIs, a Research PI in the City funded for the elimination of Hepatitis B at NYU. And there again as part of our program, we had discussed with Councilwoman Chin about the possibility of something similar bringing that up. But actually expanding it

to Hepatitis C, as part of our work with the Hepatitis C community also. And I can say that given the perspective of these years, since 2007, when this was brought up I don't know how many thousands of people have died from Hepatitis C in New York City or from Hepatitis B. I don't think the Department of Health has any data to really tell you how many have. I mean, they do have some data of newly diagnosed, and they have some data on people who have died. But the data is very, very incomplete, and I don't think without data like that you can really make the impact that you need to make. And similarly for Hepatitis B, there were thousands. Well, maybe fewer, but there are lots of people who have died from Hepatitis B infection in that period of time. And I think that's particularly tragic in this day and age when for Hepatitis C you have a curable disease. Recent data from the CDC shows that a Hepatitis C will decrease the lifespan by 15 years for just monoinfected, and this is not co-infected, but this is monoinfected, and that the annual death is probably 10 to 12 times higher than the general population. So when you have a treatment that is currently available that can prevent that, I think

it's very tragic that we're not doing more to do that. For Hepatitis B, it's not curable, but it is certainly treatable, and it's been shown that you can prevent deaths and cirrhosis. So there, too, you have something where you have very effective therapeutics, but not enough is being done. I would say that that having the metrics is critical and important because without that, we really don't know how to judge any kind of programs. The Metrics for HIV are very, very good in New York City. they come out twice a year. They provide all kinds of metrics. And the metrics for Hepatitis B and Hepatitis C are very, very incomplete. Where they have great metrics is on the Perinatal Program, prevention program. And here is something where the Department of Health devotes two-thirds of their Hepatitis personnel working on this. When, in fact -- And I'm a pediatrician so I deal with these all the time. Where, in fact, there are 1,500 -- there's 1,600 women a year who are Hepatitis B infected who give birth in New York City. And the failure rate for the vaccine that's currently use is about 2%. So, you have essentially 24 personnel working to potentially identify those 40 kids or so who are-- So two kids

per personnel for those who are not -- who failed prophylaxis. Prophylaxis is automatic in all the hospitals, and regardless of what the surveillance are doing. So I think one way is we are potentially deploying those efforts to-- Those personnel to an area to where you can actually have much more effect on people who are actually currently dying. If a kid is affected by Hepatitis at birth, he is not going to have any problems for at least 20 to 30 years, and by then there will be curative treatments. I'm absolutely certain. So there is some issue in terms of I think how you use the resources. And I think for the Department of Health I would say that I applaud a lot of their efforts. They're doing a lot more, but I would say that there is an overwhelming -- [bell]. Can I continue?

CHAIRPERSON JOHNSON: If you could wrap up.

HENRY POLLACK: Sure. I think there's an overwhelming lack at least from -- perhaps on top of coming [sic] to Hepatitis C & B. Of a budget which I think is $1 to $2 billion, I would imagine that Hepatitis B and C, which is a major problem. We have more deaths in New York City from both of those

infections than HIV. That they can come up with $1 million for several [sic] families if they think that it would cost that much. There are a lot of automatic methods now. They probably could use less effective -- less expensive ways for getting information. So I think this bill is extremely important. It's also important for HHC, which has done very, very little over the many years in terms of improving the resources and management and diagnosis. And we've worked with the CDD, and shown that that was the case. And there has been tremendous institutional reluctance because it's because it's expensive.

CHAIRPERSON JOHNSON: Thank you doctor.

HENRY POLLACK: Thank you.

CHAIRPERSON JOHNSON: I apologize.

HENRY POLLACK: Sure.

CHAIRPERSON JOHNSON: We just have a bunch of other folks to hear from, and I think your testimony is very helpful, and I appreciate the fact that you think that this -- Council Member Chin and Koo and my bill would be helpful and important. Thank you.

HENRY POLLACK: It's going to be super important.

CHAIRPERSON JOHNSON: Thank you.

DR. VIVIAN HUANG: Hi, my name is Vivian Huang. I am an Internal Medicine Physician and Preventive Management trained. I'm currently the Hepatitis Program Director at the Charles B. Wang Community Health Center. Our Health Center applauds the New York City Council Members' proposal to require the New York City Department of Health and Mental Hygiene to issue an annual report on the prevention of Hepatitis B and C in New York City. I'd have to say since 2009 there has been no consistent reporting on Hepatitis B and C in New York City. I have the copy right here right now, and this is what I use, and I haven't had anything since them. I would just like to see with a show of hands here how many people actually have seen or know what EpiQuery? Okay. So I talked to Jay earlier about this, and he says that the solution to an annual report is just to go on EpiQuery. But obviously the invested people that are here today don't know about EpiQuery. I would say as a busy clinician, I don't have time to go onto EpiQuery to find all the stats

on Hepatitis B in the city. So we do applaud an annual report, but not just an annual report, but and enhance surveillance.

At the Charles B. Wang Health Center we have been dedicated to screening, vaccinating, treating, and managing Hepatitis B for other 3 decades in New York City. Our center mainly serves the Chinese-Americans. And although the Chinese account for 50% of the Hepatitis B cases, that's only half the story. The Chinese are not the only ones affected by Hepatitis B. From global statistics we know that Hepatitis B affects persons not just from Asia, but people from Africa, from the Caribbean's, from Eastern Europe, Russia, and South America. But here in New York City without enhanced surveillance or required reporting, we have no idea what the clear picture of Hepatitis is in New York City.

Our Health Center continues to do Hepatitis education outreach and screening programs all throughout New York City. But without annual reporting on Hepatitis, it is unclear if our efforts are actually impactful. And we do not know if the burden of Viral Hepatitis is decreasing or increasing in New York City. Just on another note, I recently

attended the C5 Summit on Colon Cancer Screening and Prevention in New York City. And I would have to applaud New York City for closing the gap on racial disparities with colon cancer screening. But I have to ask have we even begun to determine how wide the ratio in the ethnic disparity gap is for Hepatitis B and C? We just started now looking at the African community. But if we continue to look further, I can guarantee that we will see that many, many, many people in New York City are affected by Hepatitis B. New York City has 37% foreign blood, and that is where Hepatitis B comes from. Let me just -- I will just quickly finish. The U.S. Preventive Services Task Force now recommends Hep B screening in high-risk population, and also Hep B screening in the Baby Boom generation. So now providers are screening more, and as you screen more, you are going to find more people with Hep B. And we need an annual enhanced surveillance report. It's imperative to have this to show the magnitude of the problem with our Hepatitis. So that our providers know what to do. And I would say that the New York City Department of Health prides itself on taking care of all New Yorkers. So we ask that the Health

Department issue an annual enhanced surveillance report on Hepatitis B and C. The community need consistent and enhanced surveillance to appreciate and understand the burden of Hepatitis B and C, which affects the health and wellbeing of our patients, families, and communities. Thank you for giving me this opportunity to speak.

CHAIRPERSON JOHNSON: Thank you, Doctor. You may proceed.

PONNI PERUMALSWAMI: Sure. So my name is Ponni Perumalswami, and I'm an Assistant Professor in the Division of Liver Disease at the Icahn School of Medicine at Mount Sinai. I'm here. Good afternoon Chairman, Council Members and community members. On behalf of the Empire Liver Foundation and the Center for Study of Hepatitis C, we would like to thank the distinguished City Council Members who invited us here today to testify at this hearing regarding proposed Introduction 51-A in Viral Hepatitis. We are very pleased to provide our strongest endorsement of this proposed initiative. And strongly support dedicated funding to carry out the initiative sponsored by Council Members to enact a local law to amend the Administrative Code of the City of New York

in relation to requiring the Department of Health and Mental Hygiene to issue an annual report regarding Hepatitis B and C.

Viral Hepatitis B and C, the leading causes of liver disease, liver cancer, and liver related deaths in the United States are silent epidemics that affect over six million Americans. Many of these deaths are now preventable with early diagnosis and appropriate treatment. The tremendous public health burden of Viral Hepatitis in the U.S. remains an unmet need with inadequate screening and reporting efforts. The scope of these diseases have long been under-reported, which has severely hindered our nation's ability to reduce the spread of infection, identify infected persons, target treatment, and generate support for vitally needed research.

The City of New York is the epicenter for Viral Hepatitis, and is well poised to implement effective policies to address the impending health and economic crisis of this related Hepatitis B and C. Importantly, there are new treatments for Viral Hepatitis that are highly effective, and well tolerated that can result in disease cure for

Hepatitis C virus and disease control for Hepatitis B virus. Active research is now being done on treatments that could cure Hepatitis B as well. New York City has a large number of healthcare providers trained to treat Viral Hepatitis. Despite effective screening tests and treatments, more than half of all Viral Hepatitis infections in the United States remain undiagnosed. Many of these individuals will not know they are infected for years or decades until it has caused irreversible damage to their livers. There is a pressing need to uncover these cases to preserve liver function, prevent liver failure, and liver cancer, and thereby save millions of lives.

In the interest of time I'm going to skip towards the end of my testimony. The public health approach to addressing Viral Hepatitis is rapidly evolving. In 2014, policy achievements and pharmacological advances far surpassed efforts to identify, link to care, and treat those infected with Hepatitis B and C. The Centers for Disease Control and Prevention along with the U.S. Preventive Services Task Force recently endorsed a birth cohort based approach of routine one-time Hepatitis C screening for all persons born between 1945 and 1965.

On October 2013, New York State's Governor Cuomo signed a new section in the Public Health Law that went into effect January 1 of 2014, and requires healthcare providers in New York State to offer Hepatitis C screening to every individual born between 1945 and 1965. New York is the first and only state to have this requirement. [bell] Likewise --

CHAIRPERSON JOHNSON: [interposing] You may proceed. [sic]

PONNI PERUMALSWAMI: --U.S. Preventive Task Force recently upgraded screening recommendations for Hepatitis B and at risk persons, including those persons who were born in countries with a prevalence of Hepatitis B infection of two percent or greater, HIV positive persons, injection drug users, household contacts of persons with Hep B infection, men who have sex with men, and persons who are immune suppressed or who receiving kidney dialysis. Coordinated and effective strategies must be implemented to ensure those at risk for Viral Hepatitis related complications and death can benefit from these significant policy and pharmacological advancements. The Affordable Car Act is aiding

efforts to combat the long-term consequences of chronic Viral Hepatitis infection in the United States. The law prohibits health plans from denying health coverage based on pre-existing conditions, those with chronic Viral Hepatitis who were previously uninsured will now be able to get coverage and access to treatment.

Right now thanks to scientific advancements in healthcare reform, we have the opportunity to transform how the nation and our city deals with Viral Hepatitis. The City of New York can be transformed from an epicenter of the epidemic to a national leader, and the envy of cities around the world in saving and improving loves of citizens by implementing effective policies with dedicated funding. Meeting the challenge of this major public health crisis is imperative, and we cannot lose any time to make a positive and meaningful impact. By enacting the proposed Introduction 51-A with dedicated funding, we will together take an important step forward to address any existing gaps, to identify and care for patients with Viral Hepatitis. The Empire Liver Foundation is a non-profit foundation comprised of Viral Hepatitis providers

whose stated mission is to increase community awareness of liver diseases, provide education to healthcare providers and patients, and provide guidance to policy makers who influence the practice and signs of Hepatitis B and C.

It's members are expert healthcare professionals actively involved in the diagnosis and treatment of patients with Hepatitis B and C, and are actively involved in research and curing the disease. The members of the Empire Liver Foundation hail throughout the State of New York and include national and internationally renown key opinion leaders from the City of new York.

The Center for the Study of Hepatitis C is comprised of an internationally distinguished and dedicated group of clinicians and scientists dedicated to the care of patients with Hepatitis and advancement in scientific discovery. This policy with dedicated funding is in line with the core mission and beliefs from both the Empire Liver Foundation and the Center for the Study of Hepatitis C, and we are pleased to provide our strongest support of the proposed initiative. Thank you.

CHAIRPERSON JOHNSON: Thank you, doctor. I think that was a very well put testimony, and I would just echo your statement in saying that the City of New York can be transformed from an epicenter of the epidemic to a national leader and be with cities around the world in saving and improving the lives of our citizens by implementing this proposal. Meeting the challenge on this major public health crisis is imperative. And we cannot lose any time to make a positive and meaningful impact. I think that's what today is about, and it is my hope that government will rise to the occasion and do what is best to take care of people who are currently infected. And take care of people so that new infections don't continue to spread in the city.

So I appreciate first of all the three of you, and all of your hard work on a day-to-day basis taking care people in New York who are dealing with Hepatitis infections. Helping them, connecting with care, getting them quality care and treatment, and all of your advocacy so that you don't have to continue to do that type of work. And that we can take care of these diseases. So thank you for being here. I appreciate your testimony. It's very

helpful. It's always important that we hear from the experts outside of government who are doing this work on a day-to-day basis. And I just appreciate your presence here today. I don't have any questions. I think you actually put it succinctly, and we understand what we need to do. So thank you very much.

[Pause]

CHAIRPERSON JOHNSON: So next up we are going to have Debra Fraser-Howze, and Leatrice Wactor.

[Pause]

CHAIRPERSON JOHNSON: That's fine. Before we start, if you could 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?

LEATRICE WACTOR: Yes.

CHAIRPERSON JOHNSON: Thank you very much. You may begin.

LEATRICE WACTOR: Good afternoon everyone. Good afternoon, Honorable Chairman Core Johnson and distinguished members of the New York

City Council. My name Leatrice Wactor, from the National Black Leadership Commission on AIDS, and I'm here on behalf of the Honorable C. Virginia Fields, who is currently the President and CEO of the National Black Leadership Commission on AIDS.

While Hepatitis is the leading cause of liver cancer in the United States, and two out of every three people living with Hepatitis are unaware that they are infected. Over 245,000 New York City residents are living with Hepatitis, and an epidemic that remains virtually unknown to the generally at risk. Viral Hepatitis is a major systemic health disparity that disproportionately impacts several communities including African-Americans, Latinos, Asian-Americans, and Pacific Islanders across all five boroughs of New York City. Among African-Americans chronic disease, liver disease, often Hepatitis C related is the leading cause of death for persons age 45 to 64 years old. Latinos experience some of the highest rates of Hepatitis C infection in the United States. Hepatitis B -- Okay, sorry. I apologize -- and Hepatitis B.

Viral Hepatitis is the leading cause of liver cancer in the United States, and two out of

every three people living with Hepatitis are unaware that they are infected. Viral Hepatitis is a major system health disparity that disproportionately impacts communities. Fortunately today there is now considerable hope. There is a vaccine for Hepatitis B. This is -- I'm sorry. This is -- there is no vaccine -- there is no vaccine for Hepatitis C, but there is now a cure. Both the Centers for Disease Control and Prevention, CDC and the U.S. Preventive Service Task Force now recommend that all Baby Boomers, persons born between 1945 and 1965 receive a one-time screen for Hepatitis C. But the recommendations alone are not enough.

On October 23, 2013, Governor Cuomo took a significant step in addressing a major component of the epidemic when he signed the Hepatitis C Testing Law requiring all Baby Boomers to be tested at least once for Hepatitis C. We need both resolute leadership and sustained collaboration through funding to create and implement a health system response at the city and community level in order to alter the trajectory of this epidemic. We need to respond to the obligations presented by the New York State law, which accurately includes requiring the

New York City Department of Health and Mental Hygiene to issue an annual report regarding Hepatitis B and Hepatitis C. [bell]

CHAIRPERSON JOHNSON: You may continue.

LEATRICE WACTOR: Okay. Annual Reports issued by the New York City Department are key to reducing these Viral Hepatitis disparities. We would like to server, number one, and educate the community about the silent epidemic and its impact. Improve awareness of how Viral Hepatitis is transmitted, and can be prevented. Increase vaccination coverage for Hepatitis A and B. Getting people tested if they have been exposed to Hepatitis. And connecting those infected with chronic Hepatitis with care and treatment to help them stay healthy.

Funding those the New York City Department of Health and Mental Hygiene Hepatitis Control Program Citywide Initiative is designed to address and eliminate health disparities in Viral Hepatitis as well as prevent, educate, test, and treat erratic Hepatitis C and Hepatitis B in all five borough. The program also includes patient and community education, surveillance, and evaluation. Addressing health disparities is a key component of

the Department of Health Hepatitis Infection Control Program Citywide Initiative. The National Black Leadership Commission on AIDS, Incorporated supports efforts of the New York City Council Committee on Health to amend the Administrative Code as well as funding to address these urgent and highly infectious diseases. Please fund the $2.5 million to HHC for public/private partnership, and also the $5.8 million to DOH Infection for the Hepatitis Infection control Unit. Thank you.

CHAIRPERSON JOHNSON: Thank you very much.

DEBRA FRASER-HOWZE: My name is Debra Frazer-Howze.

CHAIRPERSON JOHNSON: If you could please turn your mic on. Just hit the button right there. Thank you.

DEBRA FRASER-HOWZE: My name is Debra Fraser-Howze, and I'm the Senior Vice President of Government External Affairs at OraSure Technologies. OraSure is a diagnostic company, and we make tests particularly for infectious diseases. We're a small company, about 200 people out in Pennsylvania on a brownfield [sic]. So we are ambitious in the kinds

of tools that we make and partnerships that we engage in, particularly with government. Because as quiet as it's kept, our first focus is public health, and making sure that we get a lot more joy out of saving lives than we do with just the return on investment.

I don't have a lot prepared around this, but I have been active in watching this process unfold for quite some time. And I understand that there are concerns with issues that went to the Council around the Department of Health's proposal for the Infection Control Unit, Hepatitis Infection Control Unit and the HHC Proposal for a public/private partnerships.

Quite some time ago when Commissioner Farley was still here, Commissioner of Health under the Bloomberg Administration, we were invited in, and asked to help support some work that the Department of Health wanted to do around Hepatitis C. In working with the Department, my background is that I am the former President of the National Black Leadership Commission on AIDS here in this city. And it's an organization that I ran here in this city for about 25 years.

So the advocacy hat. I'm here in my advocacy hat and in that role. Clearly, we could not even look at helping without the Department making its own decisions about what its own needs were. So I want to clarify that those proposals sent to the Council both by the departments and others in the community were done by and for the Department of Health and HHC as an assessment of their own needs.

Now, I know that we're here to talk about this report, which I think has to be done. The Governor's law requires that a report be done, and the Governor signed the bill in October 2013 saying that anybody born in the Birth Cohort 1945 to 1965 that enters any healthcare setting has to be offered a Hepatitis C test. That is the law, and I would suppose that the departments drew up their proposals one because they understand their severe deficits. Two because they understand that these types of partnerships will help them get as many people tested for Hepatitis C. And three, because they have a mandate to do it, and the mandate has already started

Do I wanted to sort of clarify that it is their work. It is their best assessment of what they need to get the job done. And the second thing I

need to clarify is industry coming to the table as a question around just giving tests or just being in a box and not really looking at how industry can give money and other services and goods to the city and that's not the case. In these discussions that we've had with DOH and HHC, we've broadened that thought and that offer. People are coming through in industry to offer resources, money, both human, and financial to help move the Hepatitis C testing, and it added Hepatitis B. Because one of the things that we're made to understand is that adult education and vaccines were of paramount importance.

So I understand that we've moved to probably a proposal that focuses on community organizations, and we're all in support of that. I think all of the community organizations are in support of that. We're certainly in support of that. We'd like to see how more we can help with that. So that's not the issue. The issue is to do one and not the other.

CHAIRPERSON JOHNSON: [interposing] I understand.

DEBRA FRASER-HOWZE: To give and give the Department of Health and HHC the burden of the law that says that they have to offer testing.

CHAIRPERSON JOHNSON: [interposing] Thank you, Debra.

DEBRA FRASER-HOWZE: And those burdens without resources is just impossible.

CHAIRPERSON JOHNSON: I understand that's why we have to redouble our efforts. We have to do more, and we have to make sure this is done in a comprehensive and piecemeal manner.

DEBRA FRASER-HOWZE: [interposing] Right.

CHAIRPERSON JOHNSON: And you have my word, and I believe this Committee's word that we will continue this fight, and make sure that the City does what it needs to do prevent infections moving forward, get people tested. To understand that if they are infested, and connect people with care to be treated who do have the virus. So I really appreciate you both being here today, and for your testimony and all of your advocacy. Thank you very much.

DEBRA FRASER-HOWZE: Thank you.

LEATRICE WACTOR: Thank you for the opportunity.

CHAIRPERSON JOHNSON: Next, we are going to hear from Crystal Jordan and Daniel Raymond.

[Pause]

CHAIRPERSON JOHNSON: Thank you, Ms. Jordan and Mr. Raymond, if you would 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 respond honestly to Council Member questions? Thank you very much. Mr. Raymond, how about you start?

DANIEL RAYMOND: Thank you. My name is Daniel Raymond. I'm the Policy Director for the Harm Reduction Coalition. Council Member Johnson, I particularly want to thank you for your support of the Hepatitis C [sic] Injection Drug because your help earlier this month where we did talk about the issue of Hepatitis C. And Council Member Chin I really appreciate and respect you for your long history of leader and persistence on this issue, and continuing to bring it forward into City Council. We are supporting this legislation. We understand that there are concerns and considerations over some of

the scope and specifics of what the Health Department is being tasked with. However, we think that it's critical as a foundation build upon, to really document both the needs and the burdens of our Hepatitis in the city, and what the most effective strategies are to advance our work. And to make sure that we have the resources that we need to do that.

In terms of Hepatitis C, I think that there are a number of areas where greater work in the City in terms of reporting on an annual basis would be helpful. So we already heard the discussion of the concern about new infections particularly among younger people who inject drugs. That level of surveillance is really critical for us to target resources so that we can make sure that we're steering our prevention efforts in the right direction, and know which parts of the city, and which populations are experiencing these infections.

We also are concerned with monitoring the implementation of the new testing law that Ms. Fraser-Howze spoke of. And I think that we have some very interesting models on the HIV side that we can look. Where HIV has constructed what's called the treatment cascade or continuum of care which measures

what portion of the estimated number of people who are infected on the HIV side have been tested and diagnosed? Of those that have been diagnosed, what proportion have been linked to care and are retained in care. And then what proportion initiate treatment and are successful in treatment. Those are very much the same questions that we have for Hepatitis B and Hepatitis C. And it will take a significant amount of work to figure out what those answers are.

But once we have that care continuum constructed, we can figure out where the gaps are, where the holes are, and where people are falling through the cracks. And most importantly, how that intersects with health disparities, and how we can take a health equity approach to make sure that we're leaving nobody behind with these revolutions and advances in treatment.

I also wanted to suggest that we need to take a balanced approach as we think about mobilizing the resources to address this epidemic. Our community-based organizations have been in the vanguard, and in the forefront of this fight. If we're truly committed to not leaving anybody behind, then we need to invest in the organization's most

effective and capable of reaching the populations that are struggling with the burden about our Hepatitis in this city in tandem with supporting efforts around reporting and surveillance, greater Health Department efforts, and the efforts of HHC. Thank you for your attention and time.

CHAIRPERSON JOHNSON: Thank you very much. If you could just turn the mic to you a little bit more to speak directly in. Yes, thank you very much.

CRYSTAL JORDAN: I'd like to thank the Chair and the members of the City Council Committee for convening this hearing, allowing me the opportunity to testify before you today. I'm Crystal Jordan. I'm Crystal Jordan. I'm the VP of Health Services at Harlem United. Harlem United serves Central Harlem, East Harlem, South Bronx, and certain sections of Brooklyn. We offer a continuum of primary care, dental services, mental health services, harm reduction, and substance abuse services as well as supportive housing, community based outreach education, and screenings for HIV, Hepatitis C, and STIs.

Traditionally, our target population has been those suffering with HIV. We've recently expanded our target population to include homeless individuals. We support legislation that would mandate reliable measures of the Hepatitis epidemic in New York City with the appropriate funding, as well as appropriate funding for addressing the necessary services to relieve people who are suffering from this disease.

In 2013, HU enrolled 365 clients with HCV at our two health centers and our mobile units. Of those that we enrolled, 157 were co-infected with HIV and AIDS; 208 were monoinfected. This represents 60% of our clients living with HIV and 30% of HU's total client population. HU conducted over 2,000 HCV tests at our health centers and mobile units in 2013. With 297 or nearly 15% testing positive. And so, as a frontline community-based organization, we support the City's strategic efforts to reduce the illness, and deaths related to HCV in the city. But specifically, our experience teaches us that focusing on the following will go a long way toward addressing the deadly epidemic.

And that's developing seamless linkage of care system that will allow providers to navigate, and patients to self-manage many hurdles specific to success treatment of this illness including the numerous specialty visits. The alcohol and substance abuse use -- Alcohol and substance use screenings, medication adherence, and the numerous requite laboratories as well as ancillary services. Many patients with HCV face social barriers, behavioral health issues, and substance abuse issues, and have co-occurring medical conditions that make it challenging for them to initiate care and remain in HCV related medical are.

Almost 50% of our HCV clients are dealing with abuse and other health issues. The second strategy for helping to address this issue would be to invest in provider education, or to increase the ranks of providers who are prepared to treat individuals with a multiplicity of chronic conditions as they present. Because our patients with HIV also have HCV, which complicates the issues. But they may also have Diabetes. They also have hypertension, asthma, and other issues such as homeless, lack of housing, and lack of income. And finally, we urge the

City to work with the State to improve access to life medications by reducing and medicating across barriers related to paying for treatments.

So as we indicated earlier, we support the measures to appropriate use of surveillance -- to implement surveillance for this issue as long as it's appropriately funded. But it's also important to support the providers because people suffering with this disease it's very -- it takes a lot of support services to get them prepared to even begin treatment let along successfully complete treatment. Thank you.

CHAIRPERSON JOHNSON: Thank you both very much for your testimony and for being patient, and for coming today to advocate on behalf of those that you serve here in New York City many of whom I know are disenfranchised and may not always have a voice. So you being here today on behalf of them I think is incredibly important to this Committee and this Council and I appreciate your testimony and your thoughts. Thank you.

CRYSTAL JORDAN: Thank you.

[Pause]

CHAIRPERSON JOHNSON: And our final two folks that we're going to hear from today, Ronni Marks and Dande Lee [sic].

[Pause]

CHAIRPERSON JOHNSON: If you would 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?

DON B. LEE: Yes.

CHAIRPERSON JOHNSON: Ms. Marks, why don't you start first.

RONNI MARKS: Thank you for ...

CHAIRPERSON JOHNSON: If you could just turn your mic on.

RONNI MARKS: Okay. Thank you for inviting me here today. My name is Ronni Marks, and most of you know as we have meetings regarding HCV for years. I am the founder of the Hepatitis C Mentor and Support Group, an organization that was formed to address the lack of supportive services for people living with Hepatitis C. Including patients co-infected with other conditions such as HIV, Hepatitis B, and preimpulse [sic] liver transplant.

I am also the facilitator of a Hepatitis C patient support group, but I am here today a Hepatitis C patient and also a Baby Boomer.

The CDC now recommends an age-based screening strategy consisting of a one-time screening blood test for HCV for those at highest risk, including people who have ever injected drugs and everyone born between 1945 and 1965. Approximately 75% of HCV infections in the U.S. exists among Baby Boomers. One in 30 Baby Boomers in the U.S. has HCV. The CDC recommendation was endorsed by the U.S. Services Task Force in June 2013. And as most of you know, New York was the first state to pass a bill requiring hospitals and healthcare providers to offer a test for Hepatitis C.

The broader testing recommendations likely will detect a substantial number of people who are unaware that they are infected. Screening for Hepatitis C should be included in all routine lab work. As my generation grows older the serious health effects of long-term Hepatitis C infection including cirrhosis, liver failure, and liver cancer will become a major burden on society. Improved diagnosis, treatment, and support services have the

real potential to reduce the dramatic increases in healthcare costs as well as the human misery. The cost of a liver transplant is $520,000, and that's without all the medications post-transplant.

I appreciate the opportunity to talk with you about this critical need for people of my generation, and many others such as underserved communities affected by Viral Hepatitis, including marginalized minority patient populations, immigrant patient communities, persons with a history of substance abuse, homeless and high-risk use. We are seeing rates -- rising rates of Hepatitis C among young people who inject drugs as well as liver cancer and mortality rates rising among African-American and Hispanic persons.

I was diagnosed with Hepatitis C in 1997. I contracted the virus from a blood transfusion. While it doesn't matter how any of us contracted the virus, before 1992, blood was not tested and there are many others walking around unaware of their status. At the time I was diagnosed, the virus was newly identified, and patients were virtually on their own to cope with the diagnosis. There was no Internet information. No patient support groups, and

no advocacy organizations to speak of. I'm going to skip a little bit just because I know we're on a time limit.

CHAIRPERSON JOHNSON: Thank you, Ms. Marks.

RONNI MARKS: Since Year 2000, I have coordinated and facilitated the Midtown Manhattan Hepatitis C Support Group at NYU Langone Medical Center. I am pleased that our group has become one of the largest in New York, and more support groups like this are needed throughout all the five boroughs. As a support group facilitator and a Hepatitis C patient, I know the sense of isolation the disease can cause, and the stigma we can feel. Despite being four times more prevalent than HIV public awareness of Hepatitis C is very low. The fact that Hepatitis C often does not cause symptoms for many years until the disease has caused severe damage to the liver may account for lack of awareness and attention. Even many primary care physicians and other healthcare practitioners know little about Hepatitis C. The lack of public awareness and understanding fuels patients' sense of isolation, and makes it more difficult. It is important for them to

gain accurate information about Hepatitis C and its treatment.

Right now a revolution in the treatment of Hepatitis C is underway. New generation direct acting anti-virals have recently become available, and an even more promising new class of drugs are in development and testing. These drugs promise a cure for individual patients, and I being one of them as I have just completed treatment, and it's looking like I am -- have been cured.

CHAIRPERSON JOHNSON: Wonderful.

RONNI MARKS: These new drugs give the ability to stem an emerging health crisis for society. They will be easier for patients to tolerate, but come at a very high cost. One pill alone is $1,000 a pill, and many patients do not have access to them. An all oral therapy for Hepatitis C infection creates new opportunities for preventing Hepatitis C related morbidity and mortality. The curative rate will greatly expand the number of persons eligible to receive treatment. Curing Hepatitis C, and eradicating this disease should be a goal of our healthcare system. To ensure the full benefits of these regimens are realized for

individuals and communities a partnership of New York City public health and community organizations can play an important role.

We must have essential services like better testing and linkage to care. Supportive services must be made available to patients from every walk of life regardless of race, gender, orientation or economic status. I urge you to please help us make sure that only New York City residents have access of Hepatitis C testing, treatment, and care. Thank you.

CHAIRPERSON JOHNSON: Thank you, Ms. Marks and I'm very happy to hear the good news for you.

RONNI MARKS: Thank you.

CHAIRPERSON JOHNSON: Thank you.

DANDE LEE: Good afternoon. My name Dande. I am CEO of Anti-Lan International [sic]. So I speak as a corporate citizen of New York City today. So there are many who have spoken earlier. So I want to touch on a couple of points. We are definitely here in support of Intro 51-A. We believe transparency reporting is key. However, there are two, three points that I would like to make, and then

the recommendations. The three points are first of all often people look at reporting as yet another task that requires tons of money. Given today's technology, we believe that if you've got the right tool it can be done. Not only can you get good reporting, you can help track and look at the entire treatment process. We don't only talk the talk, we walk the walk.

Anti-Lan is a corporate sponsor of the Hep C project. [sic]. We provided software for the project. We also worked in South Bronx with Mr. Art Padello [sp?] to make sure that crime reduction programs have the kind of technology that they need. Clearly from those two projects what we have noticed the two key things that I think need to accentuated in the reporting specifically. One of the experiences that we have is the comparison of data between the national survey versus what's happen in the Check Hep C project.

So for example in the national survey people who are homeless, people with a history of incarceration, or transgender were not even a part of the national survey. So it is important that Hep C innovation is to include those high risk

populations. And through technology we're able to make that happen. So I applaud the City Council for taking the step to make sure that these are reported.

On the other hand, of Hep B and other in general reporting, the complications of others in this age of technology in our opinion is unconscionable that people who are husbands, wives, toddlers are now just invisible because they're grouped under this other classification. These are things that are a carryover from the past with their paper forms where people are not interested in truly identifying populations of health. For all of us who are in particular support of population health, those classifications are either to be done or waivered so that we know exactly what we can do.

And I think the Check Hep C Project speaks specifically of why it's important. And the data point that were collected pointed to serious health[sic] implications. So the other point I want to make is that while the reporting is important, I think the work of the NYC Hep C task force and the Hep B Coalition must be recognized and properly supported. They need to be funded. It is only with

their knowledge and guidance that we set actual goals that can be achieved.

Lastly, speaking of Hepatitis B, very quickly, I think perhaps it is time for the city to examine other incentive programs instead of looking at a report from a historical perspective. With the Obamacare and the ACA, and all the wonderful technology that are available perhaps New York State can look at the possibility of incentivizing physicians to test and treat and target a specific area.

If 45% of those who are infected confirm Hep B in the Asian community, there should be policy and a specific incentive program given the current technology that has happened. So that's our recommendation, and we look forward to working with the City Council, and we fully supported the other -- DOHMH, and we look forward that anyway that we as a corporate citizen can participate in this process. So thank you very much for allowing me testify.

CHAIRPERSON JOHNSON: Thank you, Mr. Lee. Thank you Ms. Marks. I want to thank everyone for being here today for this incredibly important topic and for listening on Council Member Chin, Council

Koo, and my proposed bill on this topic. I look forward to working with the advocates that have come today and with the Department of Health and Mental Hygiene. I thank them for staying, and listening to the advocates' testimony, and I know that the Council takes this issue very seriously, and we'll continue to work on this. So the hearing is adjourned. [gavel]

C E R T I F I C A T E

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

Date June 27, 2014