CITY COUNCIL
CITY OF NEW YORK

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TRANSCRIPT OF THE MINUTES

Of the

COMMITTEE ON HEALTH

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HELD AT: Council Chambers – City Hall

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Chairperson

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Mathieu Eugene
Peter A. Koo
James Vacca
James G. Van Bramer
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A P P E A R A N C E S (CONTINUED)

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Office of Chief Medical Examiner

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Administration
Office of Chief Medical Examiner

Florence Hutner, General Counsel
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Claudia Calhoun, Health Advocacy Director
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Ronnie Marx Founder and Executive Director
Hepatitis C Mentoring Supporting Group, HCMSG

Christina Yang, Hepatology Physician Assistant
NYU Langone

Annette Gardino, HCV, HIV Project Co-Director
Treatment Action Group, TAG

Carlos Rosario, Wellness Advocate
Vocal New York
Appearing for Kenneth Merrick

Hiawatha Collins, Board Member, Vocal New York
Harm Reduction Coalition and Peer Network of NY

Chris Norwood, Executive Director, Health People
Appearing for: Diabetes Epidemic Must Stop
Prevention Coalition

Kendra Oke, CEO
Crossover Television Live

Mitchell Cohen
No Spray Coalition

Katherine Swan
No Spray Coalition

Esther Koslow, Chairperson
Shelter Reform Action Committee

Bill Shaklee, Legislative Director
League of Humane Voters of New York

Adelia Honeywood, Cat Rescuer
Brooklyn Cat Cafe

Laura Redman, Director
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Alex Leon, Shop Steward
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Phillip Zweig, Executive Director
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Amanda Lugg, Director of Advocacy
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Rachel Pratt, Senior Vice President
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Reed Freeland
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Sarah Kim, Hepatitis B Program Manager
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Sheila Reynoso
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Elizabeth Adams, Director
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[sound check, pause]

CHAIRPERSON JOHNSON: [gavel] Good morning. I'm Council Member Corey Johnson, Chair of the City Council's Committee on Health. During today's hearing we will address the Office of the Chief Medical Examiner's $68.4 million Fiscal 2018 Preliminary Budget as well as key indicators in the Preliminary Mayor's Management Report for Fiscal 2017. I'd like to acknowledge that the marked improvement in OCME operations under the leadership of Dr. Barbara Sampson, particularly the improvements in DNA analysis, completion times for homicide, sexual assault, and property crime cases. The Office's independent investigations inform legal proceedings and shape public health policy, and the city of New York relies upon the office's forensic biology laboratory and Forensic Toxicology Laboratory to provide and accurate services. During today's hearing, I will address the important role the office plays in the city's criminal justice system including its response to the opioid epidemic. The office's Fiscal 2017 budget included $233,000 to test for the presence of Fentanyl, a powerful synthetic opioid 50 to 100 times stronger than Morphine and $616,000 to

increase staffing and purchase equipment. I look forward to hearing about the Office's progress on these initiative as well as updates on the funding and staffing added to conduct DNA testing on gun swabs by the Parks Department. I will also address operations issues related to the office's savings, headcount and overtime as well as challenges in recruiting and retaining staff. Finally, I will touch on potential reductions in the office's state and federal funding. The Office recognizes $1.2 million in state funding and $4.5 million in federal funding in the Fiscal 2018 Preliminary Budget including grants from the National Institute of Justice, and the Urban [coughs] Area Security Initiative. Significantly, the federal government has suggested sanctuary cities such as New York may prove ineligible for Homeland Security Funding. I look forward to learning more about the office's planned services and finances in the coming fiscal year. Before we hear testimony from Dr. Sampson, I wish to thank the committee staff for the Health Committee Finance Analyst Janette Merrill, Policy Analyst Crystal Pond, and Committee Council David Seitzer as well as my Deputy Chief of Staff Louis

Cholden Brown, and with that, I'd like to welcome you Dr. Sampson and turn it over to you and your team for testimony.

DR. BARBARA SAMPSON: Thank you and good morning Chairman Johnson and thank you for those kind words. It means a lot to me personally, and also to all my very working staff that serve the people of the city of New York. [coughs] Thank you for the opportunity to testify here today. We at the Office of Chief Medical Examiner value your leadership and thank City Council for its support of our mission to serve the people of New York City during their times of profound need. I am Dr. Barbara Sampson the Chief Medical Examiner and my duty is to protect the public health and to serve criminal justice through forensic science. My personal mission is to build our Medical Examiner's Office into the ideal forensic institution, independent, unbiased, immune from undue influence and as accurate as is humanly possible. Seated with me are Dina Maniotis, Executive Deputy Commissioner for Administration, Florence Hutner, General Counsel and Dr. Jason Graham the First Deputy Chief Medical Examiner.

I want to begin by recognizing Mayor Bill de Blasio as he continues to harness the power of his administration to make New York City the most vibrant, fair safe and strong city in the nation. Deputy Mayor Dr. Hermania Palacio has also been a true partner to OCME, and I want to acknowledge the continued support and advocacy she provides on our behalf. Without these strong partnerships we could pursue our ambitious initiative to meet the evolving demands of forensic medicine and science, and to achieve our purpose, which is to provide answers in support of decedents' families and victims of crime and their families. Our strong role in guarding public health--which is one of our critical missions--can be seen as we confront the crisis of unintentional drug overdose deaths, which has swept the country. This increase in overdose deaths is primarily due to opioids including the highly lethal Fentanyl, as you said, a synthetic opiate 50 to 100 times stronger than the pain killer morphine. Earlier this month Mayor de Blasio and First Lady McCray launched Healing NYC, a new comprehensive effort to aggressively reduce opioid overdose deaths by 35% over the next five years. This investment

will strengthen our city and will directly and profoundly impact the families we serve. The New York City OCME is central in addressing the opioid epidemic in New York City. We provide invaluable data to relevant stakeholders at the local, state and national levels regarding drug related fatalities so that our public health and public safety partners can gain a better understanding of the city's drug environment and ultimately prevent overdose deaths and save more lives. The OCME has also closely partnered with the NYPD, DOHMH and the New York-New Jersey HIDTA, which stands for High Intensity Drug Trafficking Areas of the U.S. Office of the National Drug Control Policy among other key stakeholders to disrupt the opioid crisis through the RX Stat Initiative and the RX Stat Operations Working Group. This collaboration has fostered an unprecedented level of data sharing in as close to real time as possible, but timeliness of which is critical in fully investigating suspected overdose deaths and trying to prevent additional overdose fatalities. This partnership represents a primary example of how the OCME will help to accomplish the goals set forth by the Mayor and First Lady in healing NYC. Also,

central to OCME's role in helping to address this epidemic is drug toxicology testing, and now I turn to the developments in our Forensics Toxicology Laboratory. We have reduced Forensic Toxicology Laboratory turnaround times to 22 days down 80% from 108 days for the same period of the previous year for Medical Examiner cases, DWI cases and drug facilitated sexual assaults. These impressive results are due to a number of factors including intensive efficiency, and process engineering efforts. As a result of the appearance of Fentanyl either alone or in combination with other drugs such as Heroin, and increasing numbers of drug related deaths, the OCME began routinely screening nearly all autopsy cases for Fentanyl as of July 1, 2016, and completed a retrospective screening of all cases going back to January 1, 2015. The latest improvements in the laboratory allow us to routinely identify a wider a range of synthetic opioids such as Feranal Fentanyl, Despropionyl Fentanyl, Para-Florbutyryl Fentanyl and U47700 Fentanyl in addition to Fentanyl. This will be further expanded to include Carfentanil, a potent analog to Fentanyl that is currently outsourced in targeted cases. In the

past 12 months, we have an upgraded key instrumentation and trained our scientists to detect synthetic opioids. Complete validation and implementation of these tools into the laboratory is expected by the end of 2017. Through Healing NYC, OCME is now slated to receive an additional $1.6 million from the Administration in Fiscal Year 2018. With this funding, we will continue to build our toxicology laboratory's capabilities as well as recruit, hire and train two additional toxicology criminalists, two additional medical examiners, and five more medical-legal death investigators to address the increasing number of opioid related deaths, and to expand and improve the investigation of each suspected overdose fatality.

We also made significant strides in our Forensic Biology Laboratory. The OCME is fully committed to staying on the cutting edge of new technology to best meet the demands of a rapidly changing scientific world while effectively serving the city of New York. As of January 2017, we acquired and implemented a trio of new technologies in the Forensic Biology Lab. This suite of products is the Program Powerplex Fusion STR Amplification

Kit, Soft Genetics Gene Marker, HID Analysis Software and Star Mix Fully Continuous Probabilistic Genotyping Software. These new technologies enable the laboratory to better discriminate mixtures of minute samples of DNA to more effectively exonerate the innocent and assist in convicting the guilty. We are replacing our detect—DNA technology not because our older technology was flawed, but because advances in science enabled it. After conversations with the City Council last year, the OCME has published extensive validation documentation on its public facing website. In our continuing pursuit of knowledge to support high risk families and in collaboration with the Institute for Genomic Medicine at Columbia University Medical Center our Molecular Genetics Laboratory published a pilot study entitled Whole Exome Sequencing revealed severe Thrombophilia in acute unprovoked idiopathic fatal Pulmonary Embolism in a member of the Lancet Family of journals ebiomedicine in February 2017. Using advanced molecular genetic tools, we found that a substantial number of people who died of this condition, that is Pulmonary Thrombalembolism had severe Thrombphilia due to natural anti-coagulant genetic defects. In

closing, I would like to provide some clarity on one particular issue. Occasionally, families voice concerns regarding the length of time the office takes to release decedent's remains or to finalize Medical Examiner autopsy reports. Scientific standards require that we make every possible effort to positively identify each of the thousands of decedent's whose deaths we investigate every year with scientific rigor to determine their cause and manner of death. In those exceptional instances where more advanced methods are needed, the Medical Examiner process becomes more complex and time intensive. My dedicated staff and I appreciate that any delay in our service even when scientifically necessary causes hardships for families. Particularly such circumstances we take great care to work closely with families and support them through this difficult process. To summarize our budget, the OCME Non-Grant Expense Budget reflects Funding of $68.4 million in FY18 including our budgeted headcounts of 643 and a Ten-Year Capital Plan toting—totaling $71.36 million. I'm happy to answer your questions.

CHAIRPERSON JOHNSON: Thank you, Dr. Sampson. Thank you for your testimony. We have been

joined by two members of the committee, Council Member Espinal and Council Member Koo, and before we get started, I would like to just swear in all four of you who are going to be answering our questions today. If could please raise your right hand. Will you tell the truth, the whole truth and nothing but the truth in your testimony before us today?

DR. BARBARA SAMPSON: I will.

CHAIRPERSON JOHNSON: Thank you very much. So, I want to start off just talking about the contours of the budget that has been presented in the Preliminary Budget. The Fiscal 2018 Preliminary Budget as we both said, allocates a little more than $68 million to your office, which is a decrease of $544,000, which is less than 1% when compared to the budget at adoption last year. This change is largely attributable to reductions in OTPS, Other Than Personnel Services funding. In times of fiscal and financial uncertainty, additional reserves may prove necessary. Do you see any other additional opportunities for a savings in your current budget particularly related to over-estimated funding that right now is put in the budget?

DR. BARBARA SAMPSON: We have in the last couple of years made—been extremely efficient in the use of our budget to the point that we have—really know a surplus at the end of the year. Dina Maniotis can speak directly to that.

DEPUTY COMMISSIONER MANIOTIS: [off mic] Good morning, Dina—[on mic] Dina Maniotis, Executive Deputy Commissioner at OCME. WE have done—it's under $100,000 surplus at the end of the year. So in a $68 million budget and then you add our grant budget, which brings it up to $74, 75 million. At the end of our Fiscal Year, we really don't have surpluses over $100,000. That's pretty much efficient spending down to the last penny and $100,000 is over-estimating it. So it's even lower than that. So we use all of our funds very efficiently and I think effectively. We are looking, though. With OMB we've been exploring any opportunity to identify funds that we can use up as efficiencies, and—and return to OMB, and we have found some opportunities to do that.

CHAIRPERSON JOHNSON: So OCME headcount decreased by 25 positions in the Fiscal 2018 Preliminary Plan compared to the budget at adoption last year. So it went from 668 positions to 643

positions. However, the funding for personnel services for a headcount actually increases slightly during the period. How-how does that reconcile?

DEPUTY COMMISSIONER MANIOTIS: Should I--

DR. BARBARA SAMPSON: Yes, please.

CHAIRPERSON JOHNSON: If you could speak a little more closely, Dina, that would be great.

DEPUTY COMMISSIONER MANIOTIS: What that 25 headcount, grand funded headcount is really a—a reconciliation, accounting reconciliation in the financial management system for the city. It—it was in there as a relic for many years, and we have been trying to identify and eliminate it, and we did that this past few months. It really is not a—a-other than an accounting item. It's not a real loss of headcount. We have not lost any headcount. As a matter of fact with the Preliminary Budget in FY18 we will receive another nine headcount. So we're—we're at the same level. If the-the changes that you see in the budget are simply a reconcile—accounting reconciliations that we've been working with OMB to do.

CHAIRPERSON JOHNSON: So those 25 positions that we're seeing a decrease from 668 to 643 those were grant funded positions?

DEPUTY COMMISSIONER MANIOTIS: Yes. They are not CTL.

CHAIRPERSON JOHNSON: And so those headcount are gone, but--

DEPUTY COMMISSIONER MANIOTIS: Yes. It's—we just fixed our accounting. So that we have now done a-the agency has looked to reconcile our PS budget. We spent two years trying to really do a good job and eliminate any inconsistencies in our budget. We've been working with OMB, and this is part of the reconciliation process. So we identified those 25 headcounts that kept rolling in every year. We didn't actually have them. So that we eliminated that. [pause] What my AC of Finance is saying there weren't actual dollars associated with those 25 headcount.

CHAIRPERSON JOHNSON: Okay, so overtime pay at OCME has increased significantly over the past few years going from $2.8 million in Fiscal Year 2014 up to $5.1 million in Fiscal Year 2016. What drove that increase in overtime pay?

DEPUTY COMMISSIONER MANIOTIS: The primary drivers of overtime are pathology and laboratory facilities with about 21% of the increase, mortuary at 14%, and Forensic Biology, but most—some of the Forensic Biology over time is grant funded. So it's not coming out of city tax levy, and also our medical-legal investigations. So the reason for the increase has to do with a number of vacancies that we have that are in very hard to fill titles like our Medical Legal Investigators. So that accounts for some of that—that increase. As you well know, we're a 24/7 operation in all five boroughs of the city. We have to supply staff for all those shifts. The other thing that has contributed to that is simply increased workload. Our—in the last year or so, the number of team investigations in New York City has increased by 1,200, and the number of autopsies by about 600 all—mostly related to the opioid crisis. So we're increasingly busy with the same amount of staff and have problems, you know, in some areas with vacancies that we are trying to address as quickly as possible to bring down our overtime. We've realized that that is a problem, we're working very closely with OMB on how to address that.

CHAIRPERSON JOHNSON: So how many of those positions are still unfilled, the difficult positions that you need to fill?

DEPUTY COMMISSIONER MANIOTIS: Speak to the Medical-Legal—Medical Legal Investigators.

DR. BARBARA SAMPSON: Yes, yes. So right one of the one of the—the most difficult positions to recruit is the MLI, Medical-Legal Investigators, which require a degree as a physicians assistant to start with and then they go through our training. So we have just received five new positions to help meet the demand for the Opioid investigations. We've started the recruiting process. Right now, the lines don't become available until July 1. So we believe we will identify at least three of those five by July 1 and we will continue to increase our recruitment efforts. We're going to all schools that have physician assistant training. We're reaching out to any stakeholder that we can to alert them so that we can get more candidates coming into the agency.

CHAIRPERSON JOHNSON: So the slated projected amount for overtime is $3.8 million moving forward?

DEPUTY COMMISSIONER MANIOTIS: That's the budgeted amount.

CHAIRPERSON JOHNSON: That's the budgeted amount?

DEPUTY COMMISSIONER MANIOTIS: Yes.

CHAIRPERSON JOHNSON: And is it realistic that that's what the amount is going to be?

DEPUTY COMMISSIONER MANIOTIS: No, we're going to—it will be higher than that. One of the—the reasons what Dr. Sampson said is we don't operate offices. We operate laboratories and pathology centers. It's—it's more closely related to operating hospitals. So the type of engineering that we need is, you know, very expensive, and if we have any vacancies those vacancies are covered with overtime and again, we go through the list to recruit our engineers, train them and so forth. So, there is a cost—a high cost associated to operating our facilities, and we're not working closely with OMB to really realign the cost of renting the facilities with the required staffing, and we're looking at ways to mitigate the overtime.

CHAIRPERSON JOHNSON: So funding for property and—property and equipment, which is very

key to your office, it's a subsection of the OTPS budget decreased by $254,000 between the Fiscal 2018 Preliminary Budget and the budget at adoption, the largest decrease in your agency's plan. What specific property and equipment did this decrease in funding affect?

DEPUTY COMMISSIONER MANIOTIS: So the—what—the funding is really decreased from is ramp-up costs that we got in the previous budget. So in other words, for example we got 18 headcount for criminalists, and we had to purchase equipment for them, and working stations and so forth. So we got almost $100,000. That $100,000 adds into this amount. So it's really ramp-up that we got only for one time, and then in the following budgets, they're no longer there. So most of the—the decrease is in that area.

CHAIRPERSON JOHNSON: So, OCME changed mortuary service operations in June of 2015 in order to, as was stated by you all to enhance services to families and to improve operational effectiveness. All mortuary services were transferred and distributed among OCME's three primary centralized locations in Manhattan, Brooklyn and Queens.

DR. BARBARA SAMPSON: Right.

CHAIRPERSON JOHNSON: What kind of community engagement has your office provided in the Bronx and Staten Island following the closure of the morgues there to ensure residents still receive effective and efficient mortuary and autopsy services?

DR. BARBARA SAMPSON: Well, the most important thing from a family's point of view is— where they interact with the Medical Examiner's Office is in identifying their loved one. For the convenience of the families we do have places where— where families can go to identify their loved ones in all of the five boroughs including Staten Island and the Bronx. So families are still served in that way there, and indeed if for example a decedent dies in Manhattan, but their family lives in the Bronx, there's no need for them to come into Manhattan to make the identification. They can go to our Bronx Office and because the identification is done by digital photo. So that is the interaction with families for the identification process has not changed at all. What changed was the location of the autopsies, which does not directly impact families.

The—the reaction that we have had from the community has been good. I—I personally have not heard a complaint about that, and the—the funeral directors that service us we've been trying to be—make our services to them more efficient so that any increase that they have in travel time, for example, in coming to—from the Bronx say to Manhattan to pick up a body is minimized. So I think our interaction with the community on this has been successful.

CHAIRPERSON JOHNSON: So that's not what I'm hearing. What I'm hearing is from funeral parlor directors, and from the association that in the past has had a very good working relationship with your office that they feel like after the Consolidation Plan and since that time actually getting to decedents, transferring bodies, taking them out of their morgues that are outside of their boroughs or not in the Bronx and not in Staten Island has become erratic, and difficult in many ways and immediate—I'm being told that immediately upon being notified by families experiencing a tragedy, funeral directors in the Bronx and Staten Island are now notifying families not to plan a specific date or time for a funeral because of the erratic serving that's taking

place as it relates to those two boroughs. That's problematic if that's what's going on.

DR. BARBARA SAMPSON: Ab—ab—absolutely. We—I have not heard of those complaints. The—we track very closely how long it takes the relief of every single body from OCME. We track it weekly. I—we see the numbers being. Then, what?

DEPUTY COMMISSIONER MANIOTIS: Yes.

DR. BARBARA SAMPSON: They—they happen daily, right, daily, and there has been no increase that I'm aware of. We can send you all those statistics. Of course, travel time, you know, we can't help but the funeral directors are getting I think very timely service, and we'll—we'll share our numbers with you for that.

DEPUTY COMMISSIONER MANIOTIS: May I take that question?

DR. BARBARA SAMPSON: Uh-huh.

DEPUTY COMMISSIONER MANIOTIS: I think what they may—the funeral directors may be referring to is we have implemented very stringent—

DR. BARBARA SAMPSON: [interposing] Yes.

DEPUTY COMMISSIONER MANIOTIS: --QA/QC controls. That means that there is a—a forensic

qualify specialist at checkout along with the mortuary team going through a checklist of every item to ensure that we are releasing a body correctly to the correct entity. So yes, the QA/QC has been--has added more time or more complexity perhaps to what the funeral directors were used to in the past. What I can say as Dr. Sampson as she just mentioned that we do have the statistics. Before I came in here I checked yesterday's statistics. So we had 37 releases and each release averaged 26 minutes. That is we aim to go no more than an hour. That is our target, and we are doing exceptionally well in terms of all the release, and we can provide that data.

CHAIRPERSON JOHNSON: So I—I'm happy to hear that some quality assurance and control measures were put in place especially after many, many difficult circumstances--

DEPUTY COMMISSIONER MANIOTIS: [interposing] Yes, absolutely.

CHAIRPERSON JOHNSON: --that you all have put in--

DEPUTY COMMISSIONER MANIOTIS: Yes.

CHAIRPERSON JOHNSON: --given some difficulties in decedents not being identically—

properly identified. What I am being told, though, is that the statistics that you just gave me do not take into consideration the amount of time now that funeral directors are waiting outside. So they're told okay come. They come, they wait outside, and they're waiting out side sometimes for an hour or an hour and a half or two hours before the process that you just talked about actually starts. So, I'm being told by the directors that when you talk about 26 minutes or whatever the number is maybe that's when the process starts on the checklist. But the coordination of when the funeral director should actually get to the morgue is not going well. So it creates a problem where they're waiting outside in the car, in the hearse whatever it is waiting, waiting, waiting an hour, an hour and a half, two hours then the process starts.

DR. BARBARA SAMPSON: I see, yes. The—one of the ideas—I'm sure there are times when it just happens that several funeral directors come at the same time and can result in—in such delays, in particular cases. What we have thought about in the past is actually creating appointments for funeral directors so that they know that to come a 1 o'clock

and then the release will occur at 1 o'clock, and then we wouldn't schedule anyone else 'til 1:30 or 2 o'clock, and I think maybe that's something we need to look at with them if that would help.

CHAIRPERSON JOHNSON: Have you asked them if that would be a good thing for them?

DR. BARBARA SAMPSON: Well, we—we—not to—not to my knowledge. I don't think we have.

CHAIRPERSON JOHNSON: Well, I think this should be done in consultation--

DR. BARBARA SAMPSON: [interposing] Absolutely, absolutely.

BEN JOHNSON: --with them.

DR. BARBARA SAMPSON: Yes.

CHAIRPERSON JOHNSON: Okay, I—I have more questions on this, but I want to go to Council Member Vacca, and we've been joined by Majority Leader Van Bramer and Council Member Mendez.

COUNCIL MEMBER VACCA: Thank you, thank you Mr. Chair, and I'm sorry I was late. We had leadership downstairs. You touched on so much of what I wanted to speak about. There does seem to be a problem. I'm hearing it from funeral parlor

directors in my district as well. I've met with your agency about a year a half or two—

DR. BARBARA SAMPSON: Uh-huh.

COUNCIL MEMBER VACCA: --ago. We spoke because originally there was going to be a new facility in the Bronx. The plan was scrapped and I continue to hear from people that there is overcrowding at the Manhattan Mortuary because of the caseload that's been inherited from the Bronx closure. Now, is that true?

DR. BARBARA SAMPSON: What do you mean by overcrowding, of bodies or of funeral directors picking up bodies?

COUNCIL MEMBER VACCA: Both is there--

DR. BARBARA SAMPSON: [interposing] Oh, but there's no problem. First of all, the Bronx cases are divided between the Manhattan Mortuary and the Queens Mortuary. So they're not all coming from Manhattan.

COUNCIL MEMBER VACCA: Yes.

DR. BARBARA SAMPSON: As far as number of bodies, we are certainly able to accommodate that numbers that we have. As we have just discussed, the—what we call the checkout process, is more

complex now than it was a couple of years ago, which I definitely causes delays and to provide for accuracy in release, but yeah, I'll be glad—I'd really—we at OCME have not heard except in maybe very specific cases of delays. So I would very much welcome meeting again with the Metropolitan funeral directors, and addressing these concerns to see if there's anything that we can do to mitigate them.

COUNCIL MEMBER VACCA: I've been told that you sometimes have to shuttle the bodies to Brooklyn from the Bronx. Is that true?

DR. BARBARA SAMPSON: Not to my knowledge, no.

COUNCIL MEMBER VACCA: They go to Manhattan or Queens.

DR. BARBARA SAMPSON: Manhattan or Queens.

CHAIRPERSON JOHNSON: I'm—but I'm told the same thing that Council Member Vacca was told.

DR. BARBARA SAMPSON: I would very much—if you know of particular cases that you're concerned about, please let us know, but to my knowledge that does not happen.

COUNCIL MEMBER VACCA: Now, sometimes the funeral parlor directors tell me that they are unable to tell a grieving family a specific date or time for a funeral due to erratic services. Has this been a problem? I mean when you—when you—when you have the—you know, when you have a loved one who's passed on, you—I want to be compassionate, and—and if we're doing something bureaucratically that is jeopardizing that sensitivity I'd like to know.

DR. BARBARA SAMPSON: I couldn't agree with you more. There's nothing more important than completing our investigation, establishing cause and manner of deaths, filling out that death certificate, which is critical for families to proceed with their burial, and settling of estates and, of course, release of the body. We try to do that in the most timely way possible. The most the—almost all bodies are available for release the day of the autopsy. So there may be a delay in a few hours, but I have never heard of delays, you know, much greater than that. And I would really appreciate when you hear of particular cases to please ask them to—to let me know so I can investigate--

COUNCIL MEMBER VACCA: [interposing] No, I—I--

DR. BARBARA SAMPSON: --the details of what happened.

COUNCIL MEMBER VACCA: --I—I appreciate your sincerity and your commitment to addressing this, and I could arrange meetings, of course. But isn't there someone in your office who works with the funeral parlor directors on a regular basis so that these issues are existing, you should know through an intergovernmental person or some community affairs person. I—I don't know the title, but there should be communication with your constituencies namely.

CHAIRPERSON JOHNSON: It's—It's Deputy Commissioner DePaolo

DR. BARBARA SAMPSON: DePaolo, yes. Yes, Deputy Commissioner DePaolo is the--

COUNCIL MEMBER VACCA: [interposing] Is that Forensics?

DR. BARBARA SAMPSON: --responsible for Forensic Operations.

COUNCIL MEMBER VACCA: [interposing] And she--

DR. BARBARA SAMPSON: We—he--

COUNCIL MEMBER VACCA: --these issues to your--your attention?

I would—we used to have regular meetings with the Metropolitan Funeral Directors Association. There has been—my understanding there's not so much inters in that recently, but I would love to see that start again so that we can address these issues before they adversely affect families?

COUNCIL MEMBER VACCA: I—I think p-art of that disinterest could be because many of the funeral parlor directors were turned off with how the whole situation has been handled.

DR. BARBARA SAMPSON: I—I fully understand that.

COUNCIL MEMBER VACCA: They were turned off what what's happened and Staten Island and they—they just think that meeting are fruitless and they don't want to be wasting their time, so to speak.

DR. BARBARA SAMPSON: Uh-huh on those.

COUNCIL MEMBER VACCA: So that I just want you to know that's why I don't think there are meetings. So, you don't feel at this point, from what I gather from your testimony that we do need a new facility in the Bronx or Staten Island?

DR. BARBARA SAMPSON: No I do not.

COUNCIL MEMBER VACCA: You do not. Is more staffing needed at any of the locations that you now have, Manhattan, Brooklyn, Queens? Do you feel that based on the concerns that there is more staffing needed?

DR. BARBARA SAMPSON: When we consolidated our operations there was no decrease in staff. So all the staff that was working in Bronx and Staten Island were relocated to the three other facilities. With this, I really need to understand better the nature of the problems that you're bringing up now to see if increased headcount is a possible solution, or whether it's more efficiencies and perhaps things like making appointments for releases so to—to make our process more efficient and, therefore, more timely for the funeral directors. So I think there's a number of possible options we should discuss with them.

COUNCIL MEMBER VACCA: And I'm going to urge the funeral directors that I, you know, hear from to keep specific notes--

DR. BARBARA SAMPSON: [interposing] Absolutely.

COUNCIL MEMBER VACCA: --dates, times and information. But one last question. I come back to this. The facility in the Bronx that was going to be opened, if I remember correctly, was going to be opened on the grounds of Jacobi-Bronx Municipal Hospital.

DR. BARBARA SAMPSON: That's correct. I believe that's correct, yes, uh-huh.

COUNCIL MEMBER VACCA: Now, that's a city-owned HHC facility.

DR. BARBARA SAMPSON: Yes.

COUNCIL MEMBER VACCA: Why was it determined that that was not going to happen when it was planned for originally and all of a sudden what—explain to me the rational for—for having this whole consolidation so to speak?

DR. BARBARA SAMPSON: The—it was a—to—the, as you said, the new Bronx facility was in the planning phases probably for a decade. It was not really moving anywhere. The—we felt that we could better serve the people of the city of New York by consolidating our efforts in three locations rather than trying to operate five outstanding mortuaries in each of the five borough with all the additional

implementation of checkouts, through the check-out process, the quality control measures that we needed to put in place to assure that we were doing our job accurately. To do that in five locations would have been very, very difficult for a—a small agency like ours. So our decision was that it was best to consolidate those efforts in—in three locations to best serve families and to be fiscally responsible with our headcount and our—our budget.

COUNCIL MEMBER VACCA: I understand budget's implications. I also understand travel implications here, the funeral parlor directors to go from the Bronx to Manhattan it's about an hour and a half each way. That's the reality of our city unfortunately. So, it is an imposition in so much as their day is concerned, and—and not an imposition, of course. You know, they want to do the right thing by the family--

DR. BARBARA SAMPSON: Of course.

COUNCIL MEMBER VACCA: --but if there is a time element in helping other families when you have one family that demands that type of timing, you have other families who want the service. So, I thought—I thought that having a borough facility

would be optimal. You make a fiscal explanation for that. So let me ask you based on the fiscal decision you made, how much money at the end of the day was actually saved?

DR. BARBARA SAMPSON: I—I didn't mean that it was a fiscal decision. The amounts of money saved is negligible if anything. What it did allow us to do was to use our staff more efficiently, and let me just point out that--

COUNCIL MEMBER VACCA: [interposing] But were there—were there complaints with previous borough specific locations? If we're not—if this decision was made and there's no financial savings, what was the reason for it—for it? Are you operating now more efficiently than you were before? Is that your view of this insufficiency?

DR. BARBARA SAMPSON: [interposing] We are operating more efficiently, and we are operating with a much higher level of quality control, and control of our operations. To run five facilities is very challenging, to run three facilities we can do it better. Let me just point out that many states have only a single medical examiner office for the entire state. For example, Connecticut the entire

state is covered by one office. So, to have three in New York City is wonderful, and we appreciate that—that very, very much and—and we think we are—we are serving the families very well.

COUNCIL MEMBER VACCA: One last question. The Mayor has asked every agency to look at budget savings, and I'd like to know where do you anticipate finding budget savings?

DR. BARBARA SAMPSON: Well, as we said a little bit earlier, we completely—we have in the last few years had basically no budget surplus. We are a very personnel heavy agency because of the nature of what we do, scientists and physicians. So it's very difficult to cut personnel costs, of course, and our OTPS budget is relatively small. So it's very difficult for us to—to find reductions in our budget, but we are working with OMB closely to try to find areas at least where we can make some smaller—small reductions.

COUNCIL MEMBER VACCA: Thank you, Mr. Chairman.

DR. BARBARA SAMPSON: Alright, yes, please, Dina.

COUNCIL MEMBER VACCA: I'm sorry.

DR. BARBARA SAMPSON: I'm sorry.

DEPUTY COMMISSIONER MANIOTIS: I just want to add one other item. We've been working very closely with DCAS. It doesn't with the Demand or Response program to make our Forensic Science Building the Hirsch Forensic Science Building as efficient as possible, and the money, really the savings to city why they don't come back to our agency, but we have decreased the amount of energy with more efficiencies in our building, and we continue to do that. As a matter of fact, in your budget you'll see that we had Other: $57,000. That was a demand response money that we received for some of our savings, and we're slated to go to about $300,000 this year, this coming year in savings, but the savings we have that come back to us is just one point. We actually are contributing to savings for the city. So we're looking for innovative ways to do what we can to save to—to find deficiencies for the city, and as the chief said we really are personnel heavy, and we—we really can't reduce that part.

COUNCIL MEMBER VACCA: Thank you, Mr. Chairman.

CHAIRPERSON JOHNSON: So I don't want to continue to harp on this, but I have a couple more questions on this point.

DR. BARBARA SAMPSON: Great.

CHAIRPERSON JOHNSON: So, as Council Member Vacca said, what we're hearing is that with the closure of the Bronx Mortuary location, the morgue, that now sometimes Manhattan is over capacity, and when it's over capacity those bodies, which may be bodies that are associated with families in the Bronx then get sent to Brooklyn or Queens depending on where there is capacity. Is that not your understanding?

DR. BARBARA SAMPSON: No.

CHAIRPERSON JOHNSON: That's what—that's what we're being told.

DR. BARBARA SAMPSON: Yeah, no, Dr. Graham will answer that one.

DR. JASON GRAHAM: No, that's generally in accurate. The—the cases that are transferred from Manhattan, there's no body storage issue in Manhattan with cases—involving cases that are examined and released to private funeral homes for families. There are transfers of bodies from the Manhattan

facility to Queens primarily in preparation for City burial. Those are the cases that generally are transferred to Queens.

CHAIRPERSON JOHNSON: And in the case of Staten Island, as you had mentioned, Dr. Sampson, in your testimony related to the opioid epidemic and overdose deaths, a surge in the past two years has—what we're being told created a heavier burden on the Brooklyn, Kings County OCME facility with more deaths on Staten Island, and we're being told that sometimes you're shuttling between Staten Island and Brooklyn and Staten Island, and that it has created a lag in the process when it comes to the investigative process. You know, it could take an additional two days because of not having a facility on Staten Island, and that adds to the amount of time it takes for funeral directors to be able to get to see these bodies. Is that inaccurate?

DR. BARBARA SAMPSON: I—I didn't even understand it [laughs] honestly what—what—I mean, the—yes.

CHAIRPERSON JOHNSON: Well, what I'm saying is if there was a facility on Staten Island--

DR. BARBARA SAMPSON: And the--

CHAIRPERSON JOHNSON: --instead of having to shuttle back and forth between Brooklyn and Staten Island--

DR. BARBARA SAMPSON: But who? The OCME you're saying?

CHAIRPERSON JOHNSON: Yes.

DR. BARBARA SAMPSON: Okay, so when someone died in—dies in Staten Island--

CHAIRPERSON JOHNSON: [interposing] Yes.

DR. BARBARA SAMPSON: --it's regarded as an OCME case, the body used to be brought to the Staten Island office.

CHAIRPERSON JOHNSON: Yes.

DR. BARBARA SAMPSON: Now it's brought instead to the—the Brooklyn Office. Is there a little bit longer depending exactly on the geography in Staten Island transit time? Yes, but it's certainly not—it's—we're talking a—you know, a matter of hours. We're not talking two days. That's why I go confused. [laughs]

CHAIRPERSON JOHNSON: Got it. So I'm being told that because of sometimes related to the investigative process, that your office has to undertake understandably under law to do its job,

that if there was a facility on Staten Island it would take less time in the investigative process.

DR. BARBARA SAMPSON: [interposing] No, that's--

CHAIRPERSON JOHNSON: That is not accurate?

DR. BARBARA SAMPSON: That is definitely not accurate. Our investigators cover the entire—you know, we have investigators dedicated to different parts of the city, but as I told in my testimony last year we have now a tour commander system where in our Manhattan office and I--I believe you saw it when you came to visit, we can keep eyes on the entire—what's going on in the entire city at all times. So we can make very smart geographic decisions with deploying investigators who might be nearby on another case, for example, and our trucks as well that may be nearby and save time in that manner. So the—the difference is simply where the—the body ends up going in the end. But there's really no difference as far as deploying investigators in the time it takes. Of course, you know, as we are more busy, as I said, there were 1,200 more scene investigations this year than last. So there may be days where—very, very

busy days where there is a delay, but again it's hours. We're not talking—it's certainly not days. Absolutely not.

CHAIRPERSON JOHNSON: Well, I-I think all of this, the questions that Council Member Vacca and I have had on this illustrate the fact that we're hearing from the funeral directors--

DR. BARBARA SAMPSON: [interposing] Yes.

CHAIRPERSON JOHNSON: --and from the Association, and maybe the reason why you're not is that when this plan was implemented they felt surprised. They felt like they had been meeting on a monthly basis with the Deputy Commissioner De Paolo--

DR. BARBARA SAMPSON: Yes.

CHAIRPERSON JOHNSON: --from your agency and then through their monthly meetings, they were never brought into the loop until the last minute of this change being implemented where their concerns were going to be addressed and talked about in a reasonable way. And I think because of that experience, they were like why are we meeting with the Medical Examiner Office if—on something that is very significant to how we do our jobs in New York. We're not being consulted thoroughly in the lead-up

to that process and the planning of that process and the execution of that process. And so this might be an opportunity for you and Deputy Commissioner DePaolo to meet with the leadership of the association to try to talk about what happened in the past, and how you all can reset that relationship moving forward because given the job that you all have to do every single day in New York City, and given their interactions with families and residents across New York City, the work you all do is really important and especially how you do that work together. So to have a good relationship and to not have recriminations related to a process that took place two years ago I think is probably really important for your agency and for the association.

DR. BARBARA SAMPSON: I entirely agree with you. Thank you.

CHAIRPERSON JOHNSON: Okay, thank you very much. So, I'm going to try to buzz some through some of these other questions that that I have. So you talked a lot, which was great, about Fentanyl in your testimony. A recent report from the CDC indicated that the percentage of deaths caused by Fentanyl is and other synthetic opioids climbed from

8% in 2010 to 18% in 2015. As we talked about the Fiscal 2017 budget included $5.5 million to address the opioid epidemic including, $233,000 in city funding for Fentanyl testing, and $616,000 for personnel and to increase staffing, and to purchase equipment. You talked a lot about the process on how you've implemented that, and the successes related to it. Has that funding, has that amount proven sufficient to test all the bodies that you need to test for Fentanyl?

DR. BARBARA SAMPSON: As we stand today, yes, I think it is. Going forward, we don't know what, you know, the—the drug scene is changing so rapidly here. The toxicologist here and across the country are having difficulty even keeping up with the changes in the landscape. So, you know, going forward, I can't predict that there may not additional needs, but I think for right now especially with the re-engineering that Dr. Cooper did in our laboratory increasing our efficiency cross-training staff that we're very, very well positioned to address whatever may come.

CHAIRPERSON JOHNSON: Sergeant, could—could you guys shut the door outside? Excuse me,

Sergeant, could you all shut the door outside. It's a little too loud. Thank you very much. So the six budgeted positions that were associated with that amount have they all been filled?

DR. BARBARA SAMPSON: Five have been filled and one we're working on right now so we're very close, very close--

CHAIRPERSON JOHNSON: [interposing] And—and how quickly? Do you think that will be filled soon?

DEPUTY COMMISSIONER MANIOTIS: In the processing.

DR. BARBARA SAMPSON: Yes.

CHAIRPERSON JOHNSON: Okay, and then based on the recent trends that you've been looking at that the federal and state governments have been reporting? Does your office anticipate a further increase in deaths caused by heroin, Fentanyl and other synthetic opioids particularly as access to prescription painkillers is tightened? Is there anyway to project those things?

DR. BARBARA SAMPSON: I think it's extremely difficult to project this. I think the city has really taken a—a great leadership role in

addressing this problem on numerous fronts from both public safety as well as public health. So I'm optimistic that the rate rise at least will decrease and—and hopefully decrease with all these efforts, but it's impossible to say.

CHAIRPERSON JOHNSON: So I want to talk a little bit about gun swabbing. The Office's Fiscal 2017 Budget included $2 million to conduct DNA testing of all guns swabbed by the NYPD, and it included funding for 21 new positions to support this initiative. What is the status of the gun swabbing initiative? How—how are things going?

DR. BARBARA SAMPSON: From—things are going very well. The-do you have the numbers of the criminalists?

DEPUTY COMMISSIONER MANIOTIS: Yes, we hired all the positions that we received, and we hired them very quickly within under three months.

CHAIRPERSON JOHNSON: To date, how many guns have been swabbed by your office to conduct DNA testing?

DR. BARBARA SAMPSON: I don't have that number. We can---

CHAIRPERSON JOHNSON: [interposing] Do we—does any—do we have that number?

DR. BARBARA SAMPSON: No. We an get that for you. Yeah, absolutely.

CHAIRPERSON JOHNSON: And all 21 positions have been hired?

DR. BARBARA SAMPSON: Correct.

CHAIRPERSON JOHNSON: There are no current openings?

DR. BARBARA SAMPSON: No openings.

CHAIRPERSON JOHNSON: Okay, and given the relationship at least as it relates to this and many other things you all do between you all, the District Attorney's Offices and the NYPD, how has it been determined that this initiative has affected criminal investigations? Has it been worth the investment the city put in?

DR. BARBARA SAMPSON: I don't want to speak for the NYPD or the DA's Office, but my impression is that there are very, very satisfied with the services that we are providing, and that it is making a difference to them in their casework, and in law enforcement.

CHAIRPERSON JOHNSON: Okay. So I want to talk a little bit about rape test kits. OCME receives various grant funding from the National Institute of Justice, the Coverdell Program, which is a federally funded grant program and other sources to reduce the office's DNA backlog. New York State recently asked police agencies and prosecutors to report on a number of—on a number of untested rape test kits, but only 328 of the 586 agencies covered by this law responded including New York City. It was February 17th deadline to respond and report, and my understanding is that OCME did not respond to that request and report as was being asked by New York State. Do you know anything about that?

DR. BARBARA SAMPSON: I—I do not. We will definitely look into that. What was the question? How many untested rape kits we have? Is that it?

CHAIRPERSON JOHNSON: Yes.

DR. BARBARA SAMPSON: The answer is zero.

CHAIRPERSON JOHNSON: Zero.

DR. BARBARA SAMPSON: I mean except what's coming in. You know, we don't have any old

case. We've never—we—we don't—we haven't had a backlog for a decade yet.

CHAIRPERSON JOHNSON: So I think it would be important to report that.

DR. BARBARA SAMPSON: Absolutely, absolutely, we're very proud of that. Yes.

CHAIRPERSON JOHNSON: Okay.

DR. BARBARA SAMPSON: We have to look into that.

CHAIRPERSON JOHNSON: And what is the average time to test a kit?

DR. BARBARA SAMPSON: Our DNA turnaround time overall for all kinds of cases is now 44 days, and for sexual assault it's 31 days. Right?

DEPUTY COMMISSIONER MANIOTIS: Yes.

CHAIRPERSON JOHNSON: Is that--?

DR. BARBARA SAMPSON: Thirty-one days.

CHAIRPERSON JOHNSON: Sorry for not having it in front of me? Is that an increase, a decrease in the amount of time?

DR. BARBARA SAMPSON: That's a decrease. The four-month actual for FY16 was 37 days. So down to 31 days. [background comments]

CHAIRPERSON JOHNSON: Could—could we ask the folks in the hall to-? So that's great. There's a decrease, but—but that still seems like a long time so 31 days someone is raped. They show up at an emergency room. They agree to have a rape test kit done on their body, which is a very painful difficult experience for a victim. It then gets transferred to the DNA laboratory at your office, and then it takes 31 days you could have a rapist out on the streets. I mean there are other factors involved in how the police are going to conduct and investigation and use, you know, their surveillance tactics and other things they need to do to hunt a suspect and a perpetrator down but that still seems like a lot of time. Why does it take 31 days?

DR. BARBARA SAMPSON: The--

CHAIRPERSON JOHNSON: [interposing] Do we need more staff?

DR. BARBARA SAMPSON: --first off, let me—let me say that we work very closely with the Parks Department and the DA's Office to—and if they have a case that they feel the DNA results would have an impact, critical impact on public safety, that becomes a rush case, and those results can be gotten

in 24, 36, 48 hours depending on how complicated, you know, 72 hours, depending on how complicated that is. So we have--that working relationship really allows them to prioritize those cases that they feel they—that the DNA is really the critical elements in—in their investigation. Otherwise, a turnaround time of, you know, our—our target is to have a turnaround time of 30 days for the entire laboratory. That is incredibly short compared to any of the numbers I've seen nationwide. It—it-it's—you know, it's a reflection of the way we perform the tests, the efficiency. You know, when a case comes in it's not immediately started. It's—it's worked, it becomes a—I described the pod (sic) system that we had the last time we spoke. Cases are grouped and then worked through the process over a number of days. So that in itself takes some time, and then the—the turnaround time that we report is to the final signing of the report. Of course, there's QA process that occurs after we get the results, but the—the actual DNA test results are often given to the—communicated to the relevant parties, PD or the DA as soon as it is available. So that's—the turnaround time is from the beginning to the very, very end, but

there's communication with law enforcement in the meantime.

CHAIRPERSON JOHNSON: And when law enforcement says to your office hey this is a serious case. There was a violent--

DR. BARBARA SAMPSON: [interposing] Right.

CHAIRPERSON JOHNSON: --rape that occurred. We need to get these DNA test results right away, they get prioritized?

DR. BARBARA SAMPSON: Exactly. Right.

CHAIRPERSON JOHNSON: And then how quickly in that situation depending on—I know every test kit is slightly different in the amount of evidence?

DR. BARBARA SAMPSON: Right.

CHAIRPERSON JOHNSON: The clothing or what's going to present in each individual case. In a situation like that, how long would it take? A week?

DR. BARBARA SAMPSON: No, 20—no 24 hours.

CHAIRPERSON JOHNSON: 24 hours.

DR. BARBARA SAMPSON: Something like that. Of course, if it's complex it could be, you know, 36 or 72 hours, but--

CHAIRPERSON JOHNSON: [interposing] Okay.

DR. BARBARA SAMPSON: --we can't—if it's straightforward, 24 hours.

CHAIRPERSON JOHNSON: Okay, Council Member Koo has a question.

COUNCIL MEMBER KOO: [off mic] [on mic] Okay, thank you, Chair, and thank you Dr. Barbara Sampson on coming to testify. My question to you is how much federal Homeland Security grants you received last year alone?

DR. BARBARA SAMPSON: So, we received federal grants mainly from the Department of Justice. That represents about 20% of our laboratory budget, and about 7% overall of the OCME budget. So, yeah, that's about it.

COUNCIL MEMBER KOO: So in terms of our market (sic) how—

DR. BARBARA SAMPSON: Do you have them, the borrower announcements. I'm sorry, did you ask for the Homeland Security Grants?

COUNCIL MEMBER KOO: Yeah.

DR. BARBARA SAMPSON: So, yes. Homeland Security we receive $1 million a year.

COUNCIL MEMBER KOO: Okay, so—so you use it to buy the equipment?

DR. BARBARA SAMPSON: The Homeland Security money in particular supports I believe three headcounts that are—are emergency preparedness as diverse fund for mass fatality events, and what else is in that?

DEPUTY COMMISSIONER MANIOTIS: And I'd say it's probably around 70% of our Homeland Security Grants goes to spread out over the life of the grant, the salaries for the coordinators, our emergency management coordinators who then go onto manage a team of 60 volunteers within our agency to be prepared for a mass fatality in that event including training in Hazmat preparedness, and right now we're doing the HAZWOPER training, which is not just the theoretical piece, but putting our 60 volunteers through the actual functional exercise.

COUNCIL MEMBER KOO: So what happens if the—the—the funding stops? We have a new administration in DC.

DR. BARBARA SAMPSON: We are working—we would be working very closely with OMB to try to mitigate the negative effects upon the city. As Dina said, the majority—the—a lot of our emergency preparedness is volunteer based by OCME employees.

COUNCIL MEMBER KOO: Okay, my next question is about unclaimed bodies. So a new law forbids New York City from being—the use of unclaimed bodies as educational cadavers without the written consent of the next of kin. Unless the deceased was already a registered body donor. However, the note is not addressed the way bodies come to be considered unclaimed in the first place, or whether adequate measures are being taken to identify survivors. So what is the role of the Medical Examiner's Office in ultimately determining when a body should be treated as unclaimed?

DR. BARBARA SAMPSON: So the OCME manages about 10,000 bodies a year, and of that we have—it's, as you can tell, a very complex operation. We—the—before someone—we—we have established an outreach unit that looks at any unidentified individuals, and we're sub—work with our partner agencies, the NYPD, Homeless Services, MOVA and other ways to find the—

the next of kin. We also work with the Public Administrator to identify a next of kin, and any unidentified bodies are then placed also on NAMUS, which is a public facing website where loved—families who are missing someone can search for them directly.

COUNCIL MEMBER KOO: So you organization have oversight to identified all these unclaimed bodies?

DR. BARBARA SAMPSON: But it's a national website called NAMUS. Yeah, so medical examiners from all across the country put cases up there, and it's a central location where families can go, family and loved ones can go to search for them.

COUNCIL MEMBER KOO: Okay. So right now how—what was the criteria of sending bodies to—for educational purpose let's say?

DR. BARBARA SAMPSON: We—we don't send any body. We were proponents of that legislation because here in New York City with so many people especially who are from foreign countries or from—or are not in close contact with family, sometimes it takes an extended period of time for families to be identified or to come forward to even realize that their loved one has passed. So we supported this

legislation, which now require family consent before the body can be used for basically medical education purposes.

COUNCIL MEMBER KOO: Thank you.

CHAIRPERSON JOHNSON: Thank you, Council Member Koo. I just want to follow up on this. Dr. Sampson, I know that your office is diligent or tries to be diligent in conducting outreach investigations before sending bodies to Hart Island. However, recent media reports indicated that bodies of veterans are entitled to burial at a national military cemetery, and individuals with resources for a private burial ended up in mass graves. Nina Bernstein did an investigative Wrong Format (sic) piece last year that looked at what Council Member Koo was just asking about, and looked at both some of the medical facilities or—or hospitals where there are programs that take place for educational purposes. It also looked at the city. It's horrible when someone deserves a military funeral and they're getting it, and they end up in a mass grave, or when an individual has put as their last wishes that they want their body used for scientific purposes to try to help other people, and the family believes that

they're going to get a proper burial, and they end up in a mass grave. So, that Nina Bernstein from the Times I thought was very educational, and very sad in many ways that we're letting people down that have served and that have made a decision to try to use their remains to further the good of mankind, it you do good things. How do we stop that from happening? That can't happen any more.

DR. BARBARA SAMPSON: I—I agree, and this is exactly why we put together this outreach process. This is a daunting process, you know, you can imagine, you know, with a 10,000 individuals are coming through our office each year, but that's exactly what we're doing is this extensive outreach with all our partner agencies. We've really beefed up our staff with regard to that. We have, you know, strict protocols that we are following to do our best to identify each and every individual and to see if they, you know, do have the means for either a private burial, a veterans burial, et cetera.

CHAIRPERSON JOHNSON: The city of Chicago maintains a public website that lists the unclaimed dead by name, age, race, date of death and date of arrival at the city Morgue. Has your office

considered establishing such a website for the public?

DR. BARBARA SAMPSON: I think that's something that we need to look at. I don't think we've considered that. Our—a lot of time our unidentified people don't—don't have a name associated with them. So, that would be a limitation. That's why we use the NAMUS website where you can put identifying information, 30-year-old, you know, Black male--

CHAIRPERSON JOHNSON: But what if there is a name?

DR. BARBARA SAMPSON: If there is a name that would certainly be something to consider.

CHAIRPERSON JOHNSON: So are you open to exploring that?

DR. BARBARA SAMPSON: Absolutely. Sure.

CHAIRPERSON JOHNSON: Okay, Council Member Barron has some questions.

COUNCIL MEMBER BARRON: Thank you, Mr. Chair. Thank you to the panel for coming. When the Medical Examiner issues its final determinations what are the categories that are cited as the cause or manner of death?

DR. BARBARA SAMPSON: Oh, the—the cause of death is the disease or injury that is responsible for initiating the lethal sequence of events. So, you know, there's an unlimited number of—of diseases, possible diseases or injuries that could go on the—the cause or determination. The manner of death has to do with the circumstances on how the death arose, and that is either natural, which means it's a 100% caused by a disease, or violence, and then there's different subcategories of violence. So that would homicide, accident, suicide and in this jurisdiction we have a term therapeutic complication, which is a predictable complication of a medical therapy, and then in those situations where there's just not enough information for us to make determination of the case and manner of death, we can use the designation undetermined.

COUNCIL MEMBER BARRON: So if you're determination is that the circumstances were violence circumstances, and it falls in the category of homicide, how is that information useful to the district attorney in bringing forth an indictment or charges?

DR. BARBARA SAMPSON: The determination of manner of death by the Medical Examiner is a medical and scientific determination. It has no bearing on what the district attorney's office does on their cases. So there are cases for example where we call something a homicide. A homicide is simply death at the hand of another person.

COUNCIL MEMBER BARRON: Uh-huh.

DR. BARBARA SAMPSON: So even if it's in -say in self-defense for example, we would call that a homicide. The District Attorney is not at all bound by our determination of homicide. In that sort of case where it's very obvious that a case was a self defense, for example, he might not even take it to a grand jury. So the two determinations are independent of each other. We work, of course, very closely with the District Attorney's Office explaining our findings. They know what our—how we come about with our determinations, but the charges that they file are entirely separate.

COUNCIL MEMBER BARRON: How do ballistics interact with your findings?

DR. BARBARA SAMPSON: The—in a—a victim of a shooting--

COUNCIL MEMBER BARRON: Yes.

DR. BARBARA SAMPSON: --the ballistics are retrieved at the time of the autopsy, and then they are sent to the crime lab in—of the NYPD for analysis. So the analysis of the bullet itself is not done by OCME. We retrieve it, but the NYPD lab does the analysis.

COUNCIL MEMBER BARRON: Thank you.

DR. BARBARA SAMPSON: Certainly.

CHAIRPERSON JOHNSON: Thank you, Council Member Barron. I have just some final questions on staffing, which we talked a little bit about throughout your testimony, and the questions today. OCME has had difficulty hiring and retaining physicians assistants and nurse practitioners. It's my understanding that seven of the last 11 PAs and MPs hired in the last three years have left the office. Is that accurate?

DR. BARBARA SAMPSON: I have to check on that. I—I—we actually have very good retention. So I can send the retention chart. Most of our people—we have a large number, over half that have been there over 10 years. It's—I—I don't believe that we've lost that many new Physician Assistants, new

hires, but we do have challenges hiring Physician Assistants.

CHAIRPERSON JOHNSON: Well, I would like to see the retention chart, and--

DR. BARBARA SAMPSON: [interposing] And also recently we've had very good success because we've really reached out to the PA schools, done some job fair type activities, and we've had—we've been able to hire recently quite a few investigators, but it's still a challenge absolutely.

CHAIRPERSON JOHNSON: The reason why I asked because I want to understand what role salary negotiations play in these departures. Does—is compensation being used as a reason for people not staying on in these jobs?

DR. BARBARA SAMPSON: I do think that's part of it, and so much not staying on but in not even applying in the first place because a Physician's Assistant in the community and the hospital can easily earn, you know, significantly more than the salary that we are offering. We have recently raised the salary somewhat so that helps.

CHAIRPERSON JOHNSON: What's the salary, the starting salary?

DEPUTY COMMISSIONER MANIOTIS: It's gone from 81 to 83, and we've also added some additional incentives to our MLIs. For example, if they achieve their AMBDI Certification, there's another $3,000 stipend for them during—at the end of the year. So we—we're finding innovative ways. It still is a little bit of a gap between what we pay and what hospitals pay.

CHAIRPERSON JOHNSON: How big is that gap?

DEPUTY COMMISSIONER MANIOTIS: I believe—so we start at $81--$83,000. I believe that the starting salary at the hospital is closer to $100.

CHAIRPERSON JOHNSON: And how many Pas and MPs are employed by your agency?

DEPUTY COMMISSIONER MANIOTIS: We have 23 medical/legal investigators, two medical investigators, and five tour commanders, which are the highest level Medical Legal Investigator who can supervise and manage the teams.

CHAIRPERSON JOHNSON: So the—what was it, 23?

DEPUTY COMMISSIONER MANIOTIS: 20—29, 23 MLIs, 5 Tour Commanders.

CHAIRPERSON JOHNSON: That's 28.

DEPUTY COMMISSIONER MANIOTIS: 28.

CHAIRPERSON JOHNSON: Okay.

DEPUTY COMMISSIONER MANIOTIS: And two medical investigators.

DR. BARBARA SAMPSON: [interposing] Medical Investigators are doctors.

CHAIRPERSON JOHNSON: Yes.

DR. BARBARA SAMPSON: So we have two physicians that are serving this role.

CHAIRPERSON JOHNSON: So if we raise the salaries by $20,000 a year for each one of those people, or it's probably getting less than that because of the starting salary. It's not a lot of money actually in the sense of the city's budget and being able to have better retention, and that's something that you all should ask for from OMB, and if you think that's going to be helpful in retaining the staff that you need. Okay, what is the largest number of medical-legal investigators that's ever been employed? Is this the largest number, 23 that's ever been employed by the office? There's no decrease.

DR. BARBARA SAMPSON: Three plus.

DEPUTY COMMISSIONER MANIOTIS: Yeah, 23 and 5 tour commanders, 28. I would have to go historically. I'm not sure what—before I got to the agency, but this is the largest number that we've had at the agency, and we just go another five positions with the opioid funding.

CHAIRPERSON JOHNSON: Okay, I want to end with a softball for you Dr. Sampson, give that it's been a--

DR. BARBARA SAMPSON: Thank you.

CHAIRPERSON JOHNSON: --it's been a fun hearing. So, I know you're extremely passionate about the—this profession about the profession of being a medical examiner, about having young people choose pathology, and looking at this field because of the intersection between criminal justice and law enforcement and science, and getting justice to the victims and their families, and the work that you all do is really crucial, critical and important on all of those matters. One thing that we've heard, and I think that you've talked about eloquently is that it's becoming harder and harder to attract the talent needed not just in New York City, but nationally for this field of work, and the need continues to grow or

remains the same, but attracting the folks that actually want to come and do this work has been got—has gotten more difficult in many ways. How can pathology attract new talent in order to appropriately—appropriately staff medical examiner's offices here and across the country?

DR. BARBARA SAMPSON: So the lack of medical examiners is a huge problem in the United States. That is only going to get worse, and I mean much worse because the graying of our profession [laughs] the number of retirements expected in the next ten years is really going to be staggering. Right now in the United States there's probably only around 600 board certified medical examiners in the entire United States. Thirty of the work here in New York City. We are very, very fortunate and there are—this is recognized as a national crisis. So there is a lot of attention being put to this. The expansion of training programs in forensic pathology is critical. The New York City office has had an excellent training program. I am a product of it for the last 25 years training over 100 medical examiners that work throughout the country and 25 chief medical examiners. So, we're an example of a very successful

fellowship program. So increased funding, which is something that the NIJ is looking at for more medical examiner trainee positions is definitely important. However, the one big problem is the cost of medical school these days, and people going into forensics usually end up in government jobs like myself, which are not, as you know, the highest paying jobs that a doctor can get. So with the tremendous now $300 $400,000 debt that young doctors have coming out of their training to choose forensics is, you know, for some an impossibility because of the eventual low salaries. So I think something to do with loan forgiveness for people who choose forensics as that career—as their career would be a huge boom to the profession, and it's just so important. I very much thank you for bringing attention to it in this format.

BEN JOHNSON: Out of the 600 certified medical examiners in the United States, do we know how many are women?

DR. BARBARA SAMPSON: I don't know that. It's—it's-of the graduates, the one that are graduating in the last few years the majority are probably women and recap, and in our office as you

well know, it's well over half of our medical examines are women including most of our leadership with the exception of Dr. Graham [laughs] and 90% of our criminalists in our DNA lab are women. So, a lot of opportunities there.

BEN JOHNSON: It's really fantastic to hear that.

DR. BARBARA SAMPSON: Thank you. We're very proud of it. [laughs]

BEN JOHNSON: And you are the first woman to lead the Chief Medical Examiner's Office.

DR. BARBARA SAMPSON: Yes.

BEN JOHNSON: And it has been a difficult three years.

DR. BARBARA SAMPSON: Yep.

BEN JOHNSON: But I know you've worked really hard.

DR. BARBARA SAMPSON: A difficult one but very, very rewarding, and I think we're seeing the fruits of our work now.

BEN JOHNSON: Good. I mean there's a lot more work to do--

DR. BARBARA SAMPSON: [interposing] Absolutely.

BEN JOHNSON: --and I think you would admit that as well--

DR. BARBARA SAMPSON: [interposing] Definitely.

BEN JOHNSON: --and we're going to continue to be supportive, but also push you all to improve your operations for the city of New York to get even better in the panoply of important services that you all provide because it is crucial to the wellbeing of our city, and I really want to thank you for your—your time, your tenure, your service and your leadership in taking on these really important issues. I want to thank your staff as well. Thank you very much.

DR. BARBARA SAMPSON: Thank you so much.

DEPUTY COMMISSIONER MANIOTIS: Thank you.

BEN JOHNSON: We're going to take a five-minute adjournment, and up next we're going to have the Department of Health and Mental Hygiene. [gavel] [background comments, pause] [gavel] Good morning. I'm Council Member Corey Johnson Chair of the City Council's Committee on Health. During today's hearing we will address the Department of Health and Mental Hygiene's $1.5 Billion Fiscal 2018 Preliminary

Budget focusing on $635 million allocated to public health services. I will also review key indicators in the Preliminary Mayor's Management Report for Fiscal 2017. We start today's hearing [coughs] on more solid footing than we would have one week ago given the recent defeat of the misnomered American Health Care Act, and the preservation of the Affordable Care Act. We know that access to healthcare provides the—we know that access to healthcare proves vital in addressing health and equities in New York City. However, fiscal uncertainties remain. Federal funding accounts for 36% of this department's public health funding in the Fiscal 2018 Preliminary Budget and state funding accounts for 20% of the budget. The Bureau of HIV and AIDS for example receives more than $164 million in federal funding in the Fiscal 2018 Preliminary Budget representing more than 86% of that bureau's budget. We have made significant advancements in the field of HIV and AIDS, including a 17% reduction in new HIV diagnoses in New York City since 2014. That is a big, big deal. The City will need to make continued investments in HIV prevention, treatment and outreach and other public health priority areas

in order to maintain and advance this progress. This requires strategic budgeting, thorough planning, and rigorous evaluation. During today's hearing, I will address the department's new Fiscal 2018 expense funding, and will follow up on major Fiscal 2017 investments. I will also address Fiscal 2017 Preliminary Capital Commitment Plan, specifically the status of new full service animal shelters in Queens and in the Bronx. Additional areas of interest include health policy items such as the testing of drinking water in public schools, and the inspection of childcare centers and homeless shelters, and budget issues related to investments and abatement services, small cessation programs syphilis prevention efforts. I look forward to learning more about the department's plans for implementing the city's public health priorities in the fiscal year. Before I turn to you, Commissioner Bassett, I just want to say that I don't want this hearing to get totally bogged down in the uncertain future that we're trying to come to grips with and grapple with as it relates to the federal government. I saw very disturbing news yesterday that [coughs] the White House's planned budget includes over a billion in

cuts for the National institutes of Health for the Centers of Disease Control. About a $100 million of that would be directly cutting HIV and AIDS money that go to municipalities and to states, which would be devastating not just here in New York City, but across the country, and given the I think incredible partnership that we've been able to have over these last three years in instituting, implementing and coming up with new resources not just in HIV and AIDS, but on Hepatitis and Diabetes prevention and a whole host of other really important public health measures. It's a scary time to contemplate what would happen in our city to the millions of New Yorkers who rely upon the funding that we get from the federal government, and the stark reality that is presenting itself to us now. So I assume, you're going to talk a little bit about that in your testimony. I want to thank you for the A grade, and I look forward to hearing from you today. So before you testify, you could please raise your right hand both of you. Do you swear or affirm to tell the truth and nothing but the truth to this committee and respond honestly to Council Member questions?

COMMISSIONER BASSETT: I so affirm.

DEPUTY COMMISSIONER ROZZA: I so affirm.

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

COMMISSIONER BASSETT: Thank you, Mr. [off mic] Before I begin with my formal remarks, I wanted to take a moment also to reference the events last Friday. We were overjoyed and relieved that the effort to repeal Obamacare, the Affordable Care Act floundered in the House. As the Mayor pointed out, this should give all of us confidence that we can stand up to ill-conceived policies emanating from Washington, and we can continue to protect the people of the city, indeed the country. The Health Department seeks to support these efforts by providing data. We noted that 1.6 million people had their healthcare insurance in jeopardy if the Affordable Care Act was repealed, but our statistics don't always seem that compelling and what people really relate to are stories. I wanted to acknowledge, Mr. Chair, that your story that you shared about being young, uninsured with a serious medical condition that was treatable--you've always been open about your positive HIV status—made it personal, made it real. I want to thank you for how

outspoken you've been on these issues, and for your support of our efforts to protect the Affordable Care Act, and with that, I'll turn to my formal remarks. Good morning, Chairman Johnson and members of the committee. I am Dr. Mary Bassett, Commissioner of New York City Department of Health and Mental Hygiene. I'm joined by Sandra Rozza, Deputy Commissioner for Finance. Thank you for the opportunity to testify on the department's Preliminary Budget for Fiscal Year 2018. This is the start of my fourth year as Commissioner of the largest and strongest urban health department in the world. Over the last three years, my staff has worked tirelessly to protect and promote the health of all New Yorkers, but we have not done this alone. I want to thank the Council, this committee, Chairman Johnson, Speaker Mark-Viverito for being our partners and champions in this work. Together we are well on our way to ending the epidemic of HIV-AIDS in New York City the epicenter of the disease outbreak in the 1980s. In 2015, for the first time since mandated HIV reporting in New York State began, the new umber of new HIV diagnoses fell below 2,500 with no infection diagnosed among infants born in our

city, and with the Council we've paved the way for more equitable treatment of transgender New Yorkers by creating an efficient process for obtaining a gender marker change on birth certificates. Since January 2015, 731 amended birth certificates have been issued to transgender individuals up from 20 a year—thank you—20 a year in 2012 and 2013. When public health surveillance showed a sharp and steady rise in emergency department visits related to synthetic cannabinoids or K2, the Council's quick action gave City agencies the necessary powers to stop the sale of this dangerous substance and prevent further public health harm, and our response to the largest outbreak of Legionnaire's Disease ever seen in this city, the first large scale effort in North America to regulate cooling tower operations and maintenance is being looked to as a national model. In all our work, we have focused relentlessly on reducing the unjust distribution of health and wellbeing in our city. We've done this two principal ways. First by naming racism as a key determinant of health outcomes, and second by strengthening our community presence and engagement in neighborhoods for the greatest burden of disease. Last year, we

launched Race to Justice, a comprehensive effort to examine how structural racism, implicit bias, unjust practices and discriminatory policies embedded in the healthcare and public health system and all our institutions impact our decisions, interactions and priorities. This look inward reflects a message I've worked hard to push externally, that we must name racism and make injustice visible. While Race to Justice is just starting the, preliminary feedback is telling. We surveyed more than 3,000 employees, nearly half of the agency and the majority of staff said that they would like to be more active in addressing this issue. A diverse team of employees has recommended structural and policy changes within the department especially with regards to community engagement, budget and contracts, communications and workforce development and inclusion. I look forward to seeing the results of this important endeavor in the years to come. [coughs] The department will soon officially launch three neighborhood Health Action Centers in Tremont, East Harlem and Brownsville neighborhoods with disproportionately high rates of chronic disease and premature deaths. We are reimagining district health centers. The Action

Centers will bring a number of opportunities together under one roof. For example, a federally qualified health center, a family wellness suite, a multipurpose room for fitness and group activities, and so much more. Partners [coughs] including community-based organizations, clinical providers, sister agencies have already moved in, and our teams are beginning to activate the space. As one partner in Harlem noted that he has seen more people enter the building in the past three months than in the past nine years. And the Board of Health continues to enact measures to improve the health and wellbeing of New Yorkers. I am thrilled that the New York State Supreme Court and Appellate Division upheld the Sodium Warning Rule, the first of its kind in the country to require chain restaurants to post a warning icon on their menus indicating items that contain excessive amounts of sodium. While we have made strides, our work is not finished yet. It's critical not to lose site of the leading causes of death in the city, which continue to be related to chronic disease in particular tobacco and unhealthy food. New York has long been a leader in tobacco control. It remains true that if you smoke, the

single most important thing you can do for your health is to stop smoking. Obesity and diabetes continue to cast a shadow over our future health trends. I look forward to working with the Council on these issues in the coming year. I want now to turn to the Preliminary Budget. The department has approximately 6,000 employees and an operating budget of $1.5 billion of which $597 million is city tax levy. The remainder is federal, state and private dollars. The budget is the blueprint to ensuring all New Yorkers have a chance to live a healthier life. It lays out our priorities and identifies our values as an agency, administration and city. The Fiscal Year 2018 Preliminary Budget continues the department's focus on improving every community's health and making strides in the groups with the worst health outcomes. I thank the Mayor and the Council for their support. Specifically, the Preliminary Budget includes an additional $4.5 million for Cure Violence. For more than a decade, the department has defined violence as a public health concern. We've use our strongest asset surveillance data to confirm that violence can spread through communities like an infectious disease. Even

though New York City is the safest big city in the country, there are neighborhoods where gun violence continues to be a real threat. The Curve Violence Program housed within our Center for Health Equity applies measures used to stop deadly in factious diseases such as Cholera to violence prevention. With these methods, we interrupt disease transmission, working with individuals at highest risk and changing community norms. Using this model, Curve Violence deploys credible messengers to interrupt the spread of violence fueled by revenge, mentors high-risk use towards positive life choices and mobilizes community members and organizations to reject violence. What started as three sites in 2011 has grown to 18 sites. All sites recorded no shootings in the month of February and in 11 sites, there has not been a single shooting in more than 100 days. Fiscal Year 2018 funding will allow us to increase the operating budget of all 18 sites by 50% enabling them to hire additional staff, increase their capacity for supportive services. We look forward to continuing to work with the Council on this innovative public health approach to violence prevention. Also, the First Lady and the Mayor

recently launched Healing NYC a comprehensive effort to reduce opioid overdose deaths by 35% over five years. I'm excited to report that this plan will add $9.5 million to the department's Fiscal Year 2018 budget for critical investments to address the opioid epidemic. The funding will be used to quadruple our Naloxone distribution each year at full ramp up, and conduct outreach to high-risk communities, expand Bupernorphine treatment, and launch public awareness campaigns to make more New Yorkers aware of the risk of opioids.

Before our final state budget is adopted, I want to bring a couple of items to your attention that could affect the department's Operating Budget going forward. I have also expressed my concern to colleagues in Albany. The Governor's Executive Budget includes a cut in state aid provided to the department under Article 6. As you know, Article 6 provides partial reimbursement to every county in the state to provide local public health activities and services. The proposed cut, which would only affect New York City would reduce our reimbursement from 36 to 29%. [coughs] For Fiscal Year 2018, this translates to a loss of $32.5 million. If the cuts

stands, the department would be forced to reduce the number of TD health advice—Public Health Advisors as my counseling staff reduce funding for tobacco and obesity, media campaigns distribute fewer Naloxone kits and close one of our AIDS Sexual Health Clinics. The rationale for singling out New York City is that we have greater access to federal funding than other counties. However, the federal funding that we receive is earmarked for a specific programs and cannot be use for the programs affected by cuts to Article 6. Moreover, federal funding is itself at risk as I'll describe more in a moment, and I want to thank the State Assembly for rejecting this cut in their One House Budget Bill. [coughs] The Governor's Executive Budget also threatens the fiscal stability of nearly 150 school based health centers in New York City, which provide comprehensive primary medical care, dental, vision and mental health services at no out-of-pocket costs to students regardless of insurance status. These facilities increase access to healthcare for youth in our public schools, help reduce emergency department visits and prevent unnecessary hospitalization. As in past years, the Governor's plan would fold these vital programs into

the State's Medicare Managed Care Program ending fee for service billing causing some centers to close. The Assembly and Senate have included language that would permanently carve out school based health centers from Medicaid Managed Care and their One House Budget bills, and I hope you will lend your support as you have in prior years. At a time when our safety net providers are more important than ever, we cannot afford to lose any of these vital facilities. That serve children in neighborhoods that need them the most. The department has also closely monitoring Congress and the White House. As we all know, there is much uncertainty in Washington these days, and a lot is at stake that concerns the health of New Yorkers. I am pleased that the House pulled the American Health Care Act from the floor last week. However, dismantling of the Affordable Care Act remains a threat under this administration. In New York City since 2010 we've seen the uninsured rate across all age groups drop by more a third to a current all-time low of 9.3%. The repeal of the Affordable Care Act would likely reverse this trend with up to 1.6 million New York City residents at risk of losing their coverage. Those that manage to

keep their health insurance may pay more for a fewer benefits or go without needed care. New Yorkers have come to rely on their protections afforded by the ACA Preventive Services like immunizations, cancer screenings, annual wellness visits for Medicaid patients, prescription drugs coverage for Medicare recipients. All of these potential reductions would put a strain on the public health and public hospital systems, and lead to poor health outcomes from our neighbors, families and friends.

The President's budget blueprints does not provide many details regarding public health funding, but the proposed 18% cut for Health and Human Services Budget would likely have a significant impact on the department's federal funding. Specific areas of concern include the Prevention and Public Health Fund, which may be impacted by the appropriations process and comprises 12% of the Centers for Disease Control and Prevention's budget. The department receives $12 million from the fund each year to target lead poisoning prevention programs to prevent chronic conditions like diabetes and hypertension support our Public Health Lab, support activities related to vaccine and preventable

disease, and the department's CDC Emergency Preparedness Grants amount to around $30 million each year. New York City is one of the four cities directly funded by the federal government, which allows us to efficiently respond to public health emergencies and bioterrorism threats. We also face a threat of cut—of funding cut to a Title 10 and the elimination of federal funding to Planned Parenthood. The loss of financial support for life-saving preventive care including cancer screenings, prenatal visits, contraceptive services would have a devastating impact for many New Yorkers who rely on organizations like Planned Parenthood for this healthcare.

Despite the very real challenges [coughs] we face in Albany and Washington, I am grateful for a city budget that supports the department's work and advances our goal to protect New Yorkers and preserve communities, and make our city healthier, and I'm grateful for the strong support both budgetary and programmatic that we have from this committee and the Council. Before closing, I want to acknowledge my excellent leadership team who are here with me today, and all of the department's employees for continuing

to achieve so much on behalf of all New Yorkers. They bring expertise and passion to our work everyday. I'm happy to answer your questions.

CHAIRPERSON JOHNSON: Thank you, Commissioner Bassett. I appreciate your testimony, and you bringing us through the city, the state and the federal funding that the department relies upon. I don't think I need to say it in front of you because I think you agree with me, and I think most people in this room probably agree with me that—but I still think most people in this room probably agree with me that—but I still think it's important to say especially as the largest city in the United States of America [coughs] that this proposed budget by the Office of Management and Budget and by the White House in Washington is shameful. If they go through on half of what they are proposing, many people will die. It's not an exaggeration. That's not a hyperbole. That's not be trying to exaggerate what will happen. People will die. You talked about it, and I talked about it, but to show how low they will go, the American Health Care Act, the bill that was being talked about in the final hours would have eliminated the essential benefits part of insurance

plan, which covered maternity leave, wellness programs, mental health programs, substance abuse coverage. All of these things, which makes sense for all Americans and all New Yorkers, and part of what was being talked about was bringing back the ability to discriminate against folks with pre-existing medical conditions like someone who is HIV-positive like me. Eliminating the ability for young people to stay on their parents' insurance until they're 26 years old. All things that would make America sicker and would do countless harm not just to the potential 24 million folks wouldn't have access to health insurance over the next decade, but to many folks who even would be insurance, but wouldn't get the basic healthcare services that they need as part of those insurance plans. You brought us through the fact that it's being contemplated right now to cut the Department of Health and Human Services 18%, to cut the prevention and public health fund, which is part of the CDC by 12%. These are things that save lives. In times of an outbreak of HIV and AIDs or—or Legionnaires Disease or Ebola or lead poisoning in children. These are funds that save lives, and it is immoral that this is even being contemplated and

talked about. It is my hope that this department, you, the Mayor, our federal representatives, our members of Congress and Minority Leader Schumer will continue to push back against these draconian cuts that are being proposed in Washington. And that as you said in your testimony, that the reason why I think we were able to defeat this measure temporarily--because they're talking about bringing it back—in the House last week was because of Americans rising up. Americans putting up resistance through their own stories and anecdotes, talking about recovering from cancer that's gone into remission, or talking about pediatric care, or talking about the importance of Medicaid and Medicare and how it's provided health insurance coverage for tens of millions of people across this country. Because we cannot allow these cuts to stand. Now I am hopeful that yesterday when I saw this over billion dollar cut that they're proposing to the NIH, to scientific funding, to HIV and AIDS research and prevention efforts that I saw Republicans yesterday not even moderate Republicans, scary Republicans who were pushing back against these cuts. Knowing the impact it would have on their states on

municipalities within their states and saying that it's a non-starter to be asking for cuts this deep. So it is my hope that all of us collective in New York City will continue to ask New Yorkers to speak out, to tell their personal stories, and that we who have a microphone and the ability to talk to the press and have them listen will push back against this. Because the loss and impact in many ways is incalculable. We don't know how many people will die, but people will die. We don't how many people will get HIV and AIDS, but new people will get HIV and AIDS. We don't know how many new people will get cancer, but people will get cancer. We don't know at what higher rate syphilis will grow, but it will grown. We don't know how many young people will get lead poisoning, but they will be poisoned by lead if we do not do these common sense public health measures that work and that have saved lives. And so I know I'm preaching to the converted in many ways, but last week watching the news in the lead up to the collapse of what these radicals were proposing, I was discombobulated in some way saying how can this even be contemplated? How can they even be talking about these things? How is this—how can anyone sign onto a

bill that does these things. How can they sleep at night or look at themselves in the mirror every morning knowing that they're going to harm countless Americans? And so I am grateful that we live in New York City with the best health—with the best Health Department in the world, that we have a mayor that shares these values, that we have Health Commissioner that shares these values, that we have two senators that share these values, and a very sizeable congressional delegation that shares these values, and that New Yorkers are on our side, but it is my hope that we will continue to push back because some of the things that you talked about in this testimony, and some of the things that I just listed off, are not things—and I'm not criticizing the press when I say this—are not things the press writes about. They don't write about lead poisoning in children and how this will affect them. They don't write about syphilis rates. They don't write about in big ways the fact that we have driven HIV diagnosis down to the lowest level ever recorded in New York City History, and that is through these funds. That is through the federal government. That is through activism. That is through people—that is

through people putting their lives and bodies on the line. I think it's important at this moment in time at this moment in history in this alternate universe that we're living in, this cognitive dissonance that I experience everyday now in reading the news and in seeing the headlines that we talk about these things that may not be deemed sexy or headline grabbing, but are vital for the future of America and for the future of New York City. So wit that, I want to get into the questions, but I think it was important to make that statement today.

COMMISSIONER BASSETT: Thank you for that statement.

CHAIRPERSON JOHNSON: So, you—you talked about the, of course, department's budget. There aren't many new needs. There aren't any new things funded. There's the Curve Violence, which is super important. Given everything you said and I said, how was there not more to do in the city coming up with more money to do some of these things?

COMMISSIONER BASSETT: Well, as you know, Mr. Chair, the—there is new funding for Cure Violence that will enable each of the 18 sites to expand and there are new funds, the $9.5 million in Fiscal Year

18 rising up to close to $12 million in out years to tackle the still relentless rise in opioid related deaths. We've had this conversation before. I am sure you never encounter a commissioner who doesn't say that they would like to have more funding. But I am very grateful for these new funds that will use to—to address important public health issues, and we will continue to turn our attention to issues that our budget is funded for without new needs including some of the issues that I raised in my testimony and in epidemic tackling infectious diseases, tackling tobacco use, and—and obesity, et cetera.

CHAIRPERSON JOHNSON: But there's lot more work to.

COMMISSIONER BASSETT: There's always a lot more work to do.

CHAIRPERSON JOHNSON: Well, I don't want to pull the curtain back on our process, but you are always in the unenviable position of advocating for your department, which you lead, and understanding the broader context of the city's budget, and what City Hall is proposing for the needs of the entire city. I don't have to live within that context of having to sort of be respectful of these other needs.

I chair the Health Committee so I can ask for more public health money, and I think we have done that successfully together on all the things we talked about. I appreciate the fact—and I'm not criticizing the Mayor when I say this—I appreciate the fact that over the last three years we have actually gotten a significant increase in your department's budget on a whole host of really important things. But I think in this time everything that you and I said at the beginning this hearing we should keep building on that.

COMMISSIONER BASSETT: Thank you.

CHAIRPERSON JOHNSON: We should do more. This is a Preliminary Budget so there will be an Executive Budget, and then we'll have an Adopted Budget and my hope is that sometime between now and the Executive Budget that on the issues that we're going to talk about today, that your agency has to tackle and deal with on a day-to-day basis that we can get more funding [coughs] because the funding is needed. Programs are working. It's making a difference. We should build on that. Now are there ways to have savings and efficiencies in every department in the city? Definitely, and we should

identify those as I'm sure we'll talk about, and figure out how to best do that. But in programs that are working [coughing] whether it be the Nurse-Family Partnership initiative that we've worked on together, and other important things. We should invest more money, right?

COMMISSIONER BASSETT: I would point out that from a public health perspective there are many sorts of interventions that will improve the public's health. So the priority of investing in pre-K, which has been a real mark key issue of this Administration, will improve the health of our population as will access to affordable housing. So when I think about the ways in which the city is investing in health, I think more broadly than just our own budget but, of course, as Health Commissioner, I am concerned with our budget, and we do always have more that we could do, satisfied with the budget that we've brought to you today.

CHAIRPERSON JOHNSON: Okay, the department's headcount decreased by 174 positions between the Fiscal 2018 Preliminary Plan and the Fiscal 2017 Adopted Budget. However, the department's headcount has grown nearly 1,000

positions during the Mayor's first term, which is great, and I thank the Mayor for adding that headcount. It's very, very important.

COMMISSIONER BASSETT: Yes.

CHAIRPERSON JOHNSON: Does this 174 position headcount reduction reflect true savings in the department's budget, or a reduction of superfluous positions that the department never filled?

COMMISSIONER BASSETT: You mean how many of them were there? Are you asking if there were any layoffs? There have been no layoffs.

CHAIRPERSON JOHNSON: What I'm asking you is the 174 positions that are being considered reduced in this plan, were those just unfilled positions?

COMMISSIONER BASSETT: [off mic] Okay, go ahead.

DEPUTY COMMISSIONER ROZZA: So, good morning.

COMMISSIONER BASSETT: [off mic] You might want to state your name. (sic)

DEPUTY COMMISSIONER ROZZA: Oh, sorry. Sandy Rozzo, Deputy Commissioner for Finance. The

174 positions actually include 25 for OCME. So it's actually 149 positions that were given—that were put up. Some it—97 of these vacancies that were not filled, and were put for efficiencies, and the rest were just grant adjustments so that we could bring down the headcount to match the awards for our grants.

CHAIRPERSON JOHNSON: How does--

COMMISSIONER BASSETT: [interposing] That—that would mean moving people onto state lines or to grant lines.

CHAIRPERSON JOHNSON: And how many of the approximate 4,700 positions in the department's current headcount remain vacant?

COMMISSIONER BASSETT: [off mic] You should answer that because it's very long. (sic)

DEPUTY COMMISSIONER ROZZA: I—the—I believe it's around 350 or so that we have in vacancies at the moment.

CHAIRPERSON JOHNSON: 350. Okay, so what--

COMMISSIONER BASSETT: [interposing] But the majority of them for less than four months.

DEPUTY COMMISSIONER ROZZA: Yeah.

CHAIRPERSON JOHNSON: So what would be helpful [coughs] if you all could get us a list of those vacant positions so we could see kind of where the vacancies are.

COMMISSIONER BASSETT: Sure. The reason that I point out that they have been mostly vacant only for less than three months is it does take time to advertise, recruit, interview, and bring people on board.

CHAIRPERSON JOHNSON: So I want to talk a bit—a little bit about procurement. The—the department and the city overall have had a persistent backlog in its contracting process for discretionary funds. Fiscal 2017 awardees that have been cleared by the Mayor's Office of Contract Services and approved by the City Council are still waiting--

COMMISSIONER BASSETT: [interposing] But there's--

CHAIRPERSON JOHNSON: [interposing] –on the department to move beyond the award letter stage. That is unacceptable.

COMMISSIONER BASSETT: The—the first thing that I want to say is I want to acknowledge that the Council designates its designations earlier

than ever that I can recall and I—we greatly appreciate that. We have executed the contracts for over half of these designations. So compared to last year when we had a number of issues with vacancies in our contracts office, and we were in a much worse position. We are about equivalent to where we were in 2015. The other or the majority of the other contracts are in a stage of going back and forth for the vendor so they're actively being pursued, and I have confidence that we will continue to do better. Please continue to designate early and we now have taken a number of steps to improve the efficiency of our contracting process. Do you want to [off mic]

CHAIRPERSON JOHNSON: So, what's the delay? Why are there major sources of delays in the contract process?

DEPUTY COMMISSIONER ROZZA: So as the Commissioner said, as of now we have 54% of the designations registered and 32% we're working with the vendors. We've had some hiring delays within our own office, within the agency's Chief Contracting Office. We added new positions this year internally to build up their capacity, and we're—we're working as hard as we can to get this done?

CHAIRPERSON JOHNSON: How—how many people are in that office, the Contracting Office?

DEPUTY COMMISSIONER ROZZA: Approximately 60.

CHAIRPERSON JOHNSON: Sixty and how many different discretionary awardees or that 60 are those 60 people dealing with?

DEPUTY COMMISSIONER ROZZA: Approximately 5—over 500 altogether when you add the member of items.

CHAIRPERSON RICHARDS: Five hundred?

DEPUTY COMMISSIONER ROZZA: Approximately.

CHAIRPERSON RICHARDS: And 50% have been awarded right now?

DEPUTY COMMISSIONER ROZZA: Have been registered, yes.

COMMISSIONER BASSETT: [off mic] Have been registered.

CHAIRPERSON RICHARDS: Have been registered.

COMMISSIONER BASSETT: [on mic] Have been registered. They're—they're done. The—of the remaining, the majority we're in a back and forth

dialogue with the vendors. So they're not stalled somewhere. They're in an active process of being registered, but they haven't been registered.

CHAIRPERSON JOHNSON: Okay. I'm going—I'm going to ask I think some rhetorical questions. Do we—do we value the work that public health providers, non-profit providers, community-based organizations, do we value the work that they do in helping our public health process in getting healthcare to New Yorkers? We value that?

COMMISSIONER BASSETT: We do.

CHAIRPERSON JOHNSON: And if we are giving money to community-based organizations that are doing this important healthcare work that do not have huge budgets, that do not have huge staffs that do not have the ability to take out loans from banks or have rotating lines of credit with banks to cover their expenses. They have payroll to meet, they have supplies to buy. They have facility operations that need to get done. They have all these things, and they get a contract, they get awarded and they wait almost a year to get the money. It's now way for us to treat folks that are doing this really important

work on behalf of the city. We have to figure out a better way. This is not rocket science.

COMMISSIONER BASSETT: We—as last year, excuse me, as last year we'd be happy to sit down with you and go through this. It is true that there are multiple steps to our contracting process, and that whenever there are multiple steps, the delay at any one of those steps sort of ripples through and the cause is an escalation in delays. I am absolutely aware of the issues that you address, and we'd be happy to sit down and go over it with you in more detail.

CHAIRPERSON JOHNSON: Okay, I mean I'm happy to sit down, but that's not really what I want. I mean what I want is this to be fixed. So I—I want the department to come up with a better way of doing this, or to have further resources or to streamline the process so that we at the City Council don't constantly hear from dozens of providers every year that come to us begging us please help, please help, why is it taking so long?

DEPUTY COMMISSIONER ROZZA: So I just want to clarify the 60 approximate staff in that office actually manage over 1,000 contracts and 5,000

small purchase orders. So it's—it's not 60 staff that are handling 500 Council designations alone.

CHAIRPERSON JOHNSON: But if we determine that we needed 10 more staff to be able to make this better, we should hire those ten more. It's worth the money instead of having this happen to these community-based organizations. I just want to fix the problem. I feel like its Groundhog Day, but every year we come before this hearing, and every year I tell you the same thing about the CBOs, and every year we're working on it. We have vacancies where—where there are multiple steps that ripple through the process. I'm not—I'm not discounting any of that, but let's fix it.

COMMISSIONER BASSETT: I appreciate that comment, and we will endeavor to accelerate the process. I just want to acknowledge once again that we greatly appreciated the Council's action in designating early, and we are confident that we've put in place a system that will be better placed to capitalize on such early designations. Please don't stop designating early.

CHAIRPERSON JOHNSON: I don't want to belabor the point. We will designate early, but it

doesn't make us feel good that when we designate early and now we're in almost April of 2017, and still almost half are not registered. That doesn't seem like success to me.

COMMISSIONER BASSETT: I understand. Yes I understand. It's much better than last year. It's about the same as the year before.

CHAIRPERSON JOHNSON: Okay. So, I want to talk about the Capital Commitment Plan of the department [coughs] that allocates nearly $400 million for 2017 to 2020 to DOHMH. The Public Health Laboratory constitutes one of the largest projects with improvements totaling more than $127 million. What is the status of the Public Health Laboratory reconstruction, and what should the public know about the importance of that project?

COMMISSIONER BASSETT: Well, the first thing to say, and I'm glad that you asked, is to speak to the importance of the Public Health Lab. The public has had the opportunity to see on multiple occasions in recent years the Ebola outbreak, the Legionnaire's outbreak, the Zika outbreath in the Caribbean and Central America last summer. The important role that the Public Health Lab plays in

ensuring that the public in New York City has access to high quality laboratory investigations, testing and so on. The Public Health Lab is true jewel in the crown of the Health Department. The efforts to address the fact that the building that the Public Health Lab is in is old and in need of renovation. We need new modern laboratory space. It's still ongoing. As you note, we have the capital in our budget, a plan that had been worked on for some years when I became—before I became Commissioner, and that I found in place as I became Commissioner fell apart when a private partner withdrew from the deal, and we are in active conversations with EDC about coming up with an alternative plan. As soon as I'm able to brief you on that plan, I will do.

CHAIRPERSON JOHNSON: So I'm con—I'm confused, Commissioner Bassett.

COMMISSIONER BASSETT: [interposing] Okay, we--

CHAIRPERSON JOHNSON: [interposing] You're saying that the--?

COMMISSIONER BASSETT: --we had a plan. We had a plan that involved bringing in a private

partner. I'm going to just state it in broad terms so it's not literal that we--

CHAIRPERSON JOHNSON: Biomedical?

COMMISSIONER BASSETT: --we would renovate six floors. They were--

CHAIRPERSON JOHNSON: Yeah.

COMMISSIONER BASSETT: --eight floors. They would get two floors. They would rent them at market rates. They would---

CHAIRPERSON JOHNSON: [interposing] Yep, it was cross-subsidized?

COMMISSIONER BASSETT: --they would—they would cross-subsidize and help pay for the renovation. Anyway, the private partner that we hope—hope to conduct this renovation they have walked away from the deal. They found it no longer financial via—financially viable. So that put us back to square one in terms of addressing the need for renovated space for the Public Health Lab. We remain committed and the money is in the budget to accomplish that renovation, but I don't have a specific plan that I can share with you today.

CHAIRPERSON JOHNSON: Is the public dollar portion that was allocated $127 million to do

that renovation and reconstruction is that enough? You can turn your mic on.

COMMISSIONER BASSETT: Oh, probably not--

CHAIRPERSON JOHNSON: [interposing] It's probably not.

COMMISSIONER BASSETT: --but we are in actual conversation--

CHAIRPERSON JOHNSON: [interposing] Because you were relying on the private partnership as well?

COMMISSIONER BASSETT: That or on additional funding. So we are, you know, we have a commitment to the development of appropriate space for the Public Health Lab and I am confident that we will meet that commitment. I think it's clear to everyone that the Public Health Lab, and I confident that we will meet that commitment. I think it's clear to everyone that the Public Health Lab plays a vital role—role in the Public Health practice of our department, and an important role in keeping the city safe. The reason that we could offer testing for Zika for example last summer was because we had a Public Health Lab that could do the testing right here in New York City, and that was why we were able

to offer such widespread testing. It's since largely been taken over by the commercial labs, but at the time of the outbreak in the Caribbean and Latin America we didn't have commercial tests, and that's where the Public Health Lab stepped in. There's no question of its importance to the agency and the city, and no question about its need for new space.

CHAIRPERSON JOHNSON: So funding for the Tobacco Control Program remains consistent in the Fiscal 2018 Preliminary Budget compared with the budget at adoption at approximately $7.5 million, but the percentage of adults in New York City who smoke has stagnated over the past few years. I know we're going to have a hearing, and we've been collaborating as a Council and with the Health Department. We're going to have a hearing later in April. So about a month from now on a package of bills that look to improve tobacco related issues in New York City. How can the City. How can the city improve the Tobacco Control Program or advise the city's Five Point Tobacco Control Plan to help reduce smoking rates if the money has remained the same, and smoking rates remain stagnant.

COMMISSIONER BASSETT: Well, the first thing to say is that the money baselined in the Tobacco Budget has gone up considerably since I became Commissioner. We were using one-time funding to bolster the budget, and it now stands at about $7 million annually. We have a number of ideas that might relate to—to—not to the costly activities. Media, for example, is a high cost item, buying media time, but we have a—a budget that's fully adequate toe address that. I have heard from advocates and perhaps also from Council Members about a desire to increase the Tobacco Control Budget, but at present we—we have a Tobacco Control Budget that provides for cessation Tobacco Control, for education, for evaluation. Legislation and taxation are—are issues that you've mentioned. Well, I don't think you mentioned taxation because that has to be done by the state, and that that—there hasn't been much action on taxation. The last time the state raise the tax on cigarettes was in 2010, and I was heartened that the Governor is looking at taxing E-Cigarettes. Maybe he'll start looking at taxing other—taxing tobacco products, but the decisions on taxation lie with the

Governor and legislation. Council Member, as you are aware, lies with the City Council.

CHAIRPERSON JOHNSON: So I'm looking forward to this hearing.

COMMISSIONER BASSETT: Sure.

CHAIRPERSON JOHNSON: And I think we've done some good collaboration and work together, and I'm really excited about this package of bills, and I know the advocates are excited about this package of bills, and I think it's been some good collaboration between the folks at the Health Department and the folks that City Council that have been focused on this issue for a while. So, we're going to have that hearing in a month, and I think that in voting on hopefully implementing some of that legislation, it will actually hopefully have an impact on decreasing rates.

COMMISSIONER BASSETT: Yes, and I do want to also note that when I became Commissioner the most recent estimate was 16% of New Yorkers smoke cigarettes and we're now down to 14%. It's not a statistically significant change, but it is a lower estimate, and I think that that's related to the fact that we did put additional funding into the Tobacco

Control budget, but there's more we could do and I look forward to working with the Council on these issues. It remains true that the single most important thing that you can do for your health if you are a smoker is to stop smoking.

CHAIRPERSON JOHNSON: Well, I'm someone that struggled with that.

COMMISSIONER BASSETT: It's hard. So am I. [laughs]

CHAIRPERSON JOHNSON: Yes.

COMMISSIONER BASSETT: It's not easy. It's highly addictive, nicotine.

CHAIRPERSON JOHNSON: And I have a lot of shame about it.

COMMISSIONER BASSETT: Yes.

CHAIRPERSON JOHNSON: I mean I don't like the fact that I struggle with that. It's hard.

COMMISSIONER BASSETT: Yeah, that's not uncommon. It's hard.

CHAIRPERSON JOHNSON: Yeah. So, I want to talk a little bit about the—the PHIP, the New York City Population Health Improvement Program Population Health Improvement Program. In January of 2015 DOHMH partnered with the Fund for Public Health in New York

and other organizations to launch the New York City Population Health Improvement Program and to achieve inclusive health planning a regional and local level. What has the New York City Population Health Improvement Program achieved to date, and what are the future objectives?

COMMISSIONER BASSETT: It's unfortunate that Dr. Barbot couldn't be with us today because she's leading that effort, but I'll do my best to address the question, and note that we would be happy to follow up with you additionally because I'm not sure if there is anybody else here. So this is a effort that's aligned with our sort of overarching policy the Take Care New York Policy, Take Care—TCNY 2020, which aims to build healthier communities to support healthy living to address the needs of children, and an important accomplishment of this work has been bringing together for joint planning both the New York Academy of Medicine and various actors in the healthcare field. The Health Department in New York City is a local Health Department. It doesn't have any direct role in what's known as DSRIP, the Designing System Reform Improvement Project. That's run by the state, but

we've been working hard to ensure that we have a voice in it, and I am pleased that we have accomplished that. Just last week or maybe the week before we convened all of the 11 PPSs in—in New York City at the Health Department to talk about ways in which they could jointly address population health issues. So I would consider that one of the important outcomes of the planning process. The—you know, the future of this is—is dependent in part on state funding. The—the initial budget was cut substantially, I regret to say from what had been initially allocated because of state funding issues.

CHAIRPERSON JOHNSON: Thank you. So I want to talk a little bit about Neonatal Herpes, and Natiza DePa (sp?) I saw an article was it today from Dan Goldberg at Political New York, which says the de Blasio Administration will attempt to ban mohels who have infected infants with Herpes from performing this controversial circumcision practice that involves sucking blood away from the wound. In the last two weeks, Health Commissioner Mary Bassett ordered two mohels to stop performing this, but the Administration not release the names of the mohels citing real concerns and then several alarmed parents

asking the mohel if they had been banned by the City Health Commissioner. So my question is there's been a bit of a back and forth going on. The Board of Health repealed the previous Administration's policy as it related to this. They put in, which—which involved consent forms from parents. They put in—you all instead put in a practice which said that if you were someone who tested positive, a mohel that tested positive he'd be banned from performing in the future. I think we can all agree that babies should not get Herpes. But there is a balance that's trying to be struck here by the Administration and working with this community on a practice that is extremely prevalent, and figuring out a way to protect newborns. While at the same time knowing that this practice isn't going to stop. This article that came out this morning that talks about the department's efforts tat taking a new go at trying to figure out how to do this. How confident do you feel that this new approach is going to be more effective than previous approaches?

COMMISSIONER BASSETT: Thank you very much for that question. Let me try and separate out the two aspects of the department's obligation when

it comes to children who have circumcision associated Herpes. The first was the issue of the Board of Health Consent Form. That was proposed under the previous administration in September of 2012, and in September of 2014 I requested that the Board of Health consider repealing the requirement that the ritual circumciser know as a mohel obtain informed consent from the parents on whom he—and it usually was a he—was going to perform the circumcision. So that's one part of—of the-of the Health Department's role. We advocated for and the Board of Health repealed the informed consent requirement. The reason that it was repealed was that it was not working. It was not being administered to the parents, and it was causing a huge uproar in the community really boiling the community, and making it more difficult to have the kind of conversations that we need to have when—when we're investigating a disease. The other part of the Health Department's role is in investigating reportable diseases, and this is a core public health function, and it's a function that we have always pursued that we always have since it became reportable examined the setting and tried to ascribe a cause to the acquisition of

neonatal herpes and take action to prevent it. What we're doing now is continuing those investigations. When a mohel is identified who is associated with the circumcision, which has happened twice since the Board of Health repealed the Consent Rule. We asked them to undergo testing to assess their risk of infection to the baby in the—in the meantime until we can fully access them ordered them not to continue to practice. So that is the Commissioner's orders. We issue Commissioner's order for lots of things, as you probably remember, we issued them around the cooling towers. In this case, we issued them with a request that they cooperate with assessment for Herpes Simplex Virus Infection and cease practicing until they do. We expect them to comply with this Commissioner's order.

CHAIRPERSON JOHNSON: So 70% of all adults. I'm not even just talking about the Orthodox community where this--

COMMISSIONER BASSETT: No.

CHAIRPERSON JOHNSON: --they're practicing. The same reason that all adults have some type or would test positive for Herpes Simplex Virus 1.

COMMISSIONER BASSETT: Very common.

CHAIRPERSON JOHNSON: Very common. You know, it doesn't maybe show up. You may not see it, but it's in your body, and depending on where it is and the stage that it's in your body, you could transmit it to another human being.

COMMISSIONER BASSETT: That is correct. You don't have to have symptoms. The symptoms of—of Herpes Simplex Type 1 are often called cold sores, and you don't have to have a cold sore in order to be shedding the virus, and therefore infectious to others. It's highly contagious. That's why so many people have evidence of infection.

CHAIRPERSON JOHNSON: And so the virus is usually harmless in adults. I mean you can get cold sores, but in infants it can be deadly?

COMMISSIONER BASSETT: That is correct.

CHAIRPERSON JOHNSON: So we don't want babies to die.

COMMISSIONER BASSETT: The department considers this an unsafe practice and we recommend that people not engage in it. Nonetheless, it is a legal practice by ritual circumcisers. The circumcision process does not have to be conducted by

a licensed practitioner, and we [coughs] know that it is a highly valued ritual, on that is replete with religious and spiritual significance. It's part of how a baby boy is welcomed into a family and the community. So in my view, the—the best strategy is to seek to educate parents. A part of our case to the Board of Health when they decided to repeal the Informed Consent, was that the clinical setting is a much better place to have a conversation about medical issues than at the brith, which is what the ritual circumcision ritual is called. And so, we have developed educational materials that we make available to hospitals, clinicians, pediatricians, obstetricians that we've circulated widely. It's available in Yiddish and English and Hebrew, and our hope is that there will be more conversations with families about the risks of this ritual in a health setting with a trusted public health professional. This seems to me the appropriate setting in which to have these conversations, and then we want to make sure that parents have full information when they make a decision about whether they want to have this take place or not. So that includes understanding all the facts that you just laid out.

CHAIRPERSON JOHNSON: So [coughs] my concern is given the history that has taken place over the course of two administrations and trying out if—to trying to figure out a policy that would protect babies, as well as respect this religious practice, which isn't going away that from what I read in this article today, this morning, and from what I've seen in previous iterations of coverage when the Board of Health and when the Health Department have tried to do things, there now seems to be a rift and some distrust between the community where this is taking place and the Health Department. Now, I don't want to—I don't want to judge that. I don't want to say that that's right or that's wrong, but I will say that for us to be able to be effective in making some good strides in the name of public health and to protect the folks we're trying to protect, there needs to be a good relationship. And I'm wondering that even with this policy of educational pamphlets and with hopeful cultural competency, and the appropriate setting and doing that outreach is that actually going to be effective?

COMMISSIONER BASSETT: Well, one thing that I want to make sure you understand is that we

have not seen children getting very sick from their Herpes infection in recent years. The baby that—whose diagnosis was made this year is doing fine. It is true that they are at risk for recurrent infection. Herpes is that type of virus having recurrent clinical episodes, but the baby is doing fine. We haven't seen any children either get very sick or have had any fatalities related to neonatal herpes related to ritual circumcision in recent years. And I feel that this is possibly related to the fact that babies are being brought in by their families more rapidly for diagnosis and treatment. That's what we want to see if the babies are exposed to and develop herpes related to ritual circumcision. This is pretty rare. We see a handful of cases every year, but it's a small but real risk, and we want parents to be aware of the risk. We want them to be aware that it is a preventable risk, one that they can choose to expose their child to or not. But I wouldn't describe this so much as a rift as the kind of almost metaphysical difference between having a—a spiritual attachment to something and a medical view of it. There are different sets of risks. I would imagine that families feel they are exposing their

infant to if they choose not to do this, and I would hope that we can continue to get information to families and communicate. That's my goal. Not to—to be either disrespectful or disparaging, but the medical view is different than the spiritual view.

CHAIRPERSON JOHNSON: [pause] So why is this the right policy now? I mean you adopted a policy in 2015, and now you're saying that that policy wasn't the right policy.

COMMISSIONER BASSETT: I'm not sure that I—we have always investigated every case, and we are continuing to do that. The difference now is that we no longer require that the mohel obtain an informed consent, and I stand by that recommendation that I made to the Board of Health, and that they acceded to in repealing the rule. The informed consent was being administered by the wrong person at the wrong time and in the wrong place, you know, at the brith, I don't know. The caterer is working outside—waiting outside. They right place to have these conversations is in healthcare settings, and we will continue to work with the appropriate healthcare settings, and seek other ways to communicate directly with the community. So, I'm not—I'm—I'm not saying

that this is a simple issue to address, but I am confident that we will continue to endeavor to ensure that parents have the information they need to make good choices, but without the consent form.

CHAIRPERSON JOHNSON: I mean I—I want to just restate that this is a complicated issue, and I'm not Orthodox, I'm not Jewish. So that's not my experience. I mean I've been to briths. But the goal here is to protect babies, and my hope is that the Health Department has crafted a way forward that is going to achieve that goal in an even better way. But also it's hard to have this conversation without having it with the community that's affected and understanding their cultural concerns, their religious concerns. Because to be effective, both sides need to be willing to work together on this, and I know in this community I want to—I don't want to generalize. But I know in this community that there are key figures that are considered leaders in the community that a lot of folks guidance from and listen to whether they be rabbis or other folks. So, I don't know what that Health Department's outreach has been to those individuals that have some real weight in how they communicate with the broader

community. And if there are folks are willing to have that conversation and go along and try to work in a way that's going to protect babies, while at the same time allow them to continue this ancient ritual and practice.

COMMISSIONER BASSETT: Well, I can only concur with you that it is a complex issue. When we identify a mohel, which we did in the two out of the six cases that have been diagnosed since the consent rule but the Board of Health was repealed. We will seek to reach out to them and work with them to assess their infection status. If—if they are unwilling to work with us, then we will impose the Commissioner's Order and that's in the interest of protecting infants. So that is an overarching goal that we share, Chairman Johnson, that we view children in particular of deserving of protection.

CHAIRPERSON JOHNSON: Thank you. So I want to talk about childcare inspections and homelessness. The Fiscal 2018 Preliminary Budget allocates nearly $15 million to the Bureau of Daycare including $7.8 million in federal funding for daycare inspections. Childcare services at city shelters, however, are not subject to the same health and

safety regulations that govern childcare facilities outside of shelters. Recent—a recent city controller investigation and report uncovered serious safety, security and health issues at shelters for families with children, and I want to understand how your department can work with the Department of Homeless Services to address these issues? [background comments]

COMMISSIONER BASSETT: So, as—as you know, the Health Department oversees the city run daycare centers, and the state funded family based childcare. We are aware of the—the concerns raised about the—the childcare settings in shelters and we're in active conversations with the Department of Social Services about this.

CHAIRPERSON JOHNSON: I apologize. I didn't see that my colleagues have been waiting to ask questions. So I want to go to them. I'm going to go to Council Member Kallos followed by Council Member Salamanca.

COUNCIL MEMBER KALLOS: Thank you, Chair Johnson and thank you for your oversight over DOHMH, and a good question. I wanted to touch base on three issues. I'm not sure if you've been paying attention

to the cover of the Post recently, but they've been focusing a lot on—on people who are homeless and appear to be experiencing mental illness. In my district we have been working with the Department of Social Services as well as the NYPD. At the last hearing the Commissioner indicated that once the individuals were brought to a hospital, it then became a DOHMH situation. So I was curious about what DOHMH's role is, and I imagine the chair was getting to the final questioning with regards to working with individuals who are mentally—who present as mentally ill on our streets?

COMMISSIONER BASSETT: Sure, I'll get started and then if there are further questions, I'm sure Dr. Belkin will be able to assist, and he'll introduce himself. The—the department has greatly expanded its ability to provide outreach services and this includes outreach services to people who are street homeless. We are better equipped than we've ever been with a whole host of teams that have various initials, the Intensive Management Team, the ACTs, which stands for Assertive Community Treatment, the Forensic Assertive Community Treatment. We have a co-response activity with the NYPD. So we have the

kinds of services that can find people where they are, and engage them in care, and follow them where they go, and ensure that they get care on a scale that we've never had in the past. You mentioned people going to a hospital, and then becoming Department of Health problems. I'm not sure that I quite follow that. Usually, when someone goes to a hospital they should be assessed in the emergency department. But certainly we—we—we receive referrals to our outreach teams from hospitals from homeless shelters, from the Correctional Health Service on Rikers Island where people sometimes leave and don't have homes and have mental health issues. So, I think that we're in a better position than we've ever been to address the issue of people who have mental health issues and not domiciles. In fact, when they—when we enroll people in our services, they're much more likely to become housed. Do you want to add anything?

COUNCIL MEMBER KALLOS: So along those lines—so specifically with regards to—to the woman who has been featured quite prominently in the New York Post have you had occasion to see any of that coverage?

COMMISSIONER BASSETT: I haven't.

COUNCIL MEMBER KALLOS: So—so is it New York Post that--

COMMISSIONER BASSETT: [interposing] I'm going to offer it to Dr. Belkin who has. Hold on.

COUNCIL MEMBER KALLOS: I believe you may need to be sworn in.

DR. GARY BELKIN: Yeah.

CHAIRPERSON JOHNSON: Yes. Do you affirm to tell the truth and to answer Council Member questions honestly?

DR. GARY BELKIN: Yes, I do.

CHAIRPERSON JOHNSON: Thank you.

DR. GARY BELKIN: So I'm Gary Belkin the Executive Deputy Commissioner for Mental Hygiene. So, we follow all the press accounts of these sort of situations. We don't attempt to comment on individual cases especially as we dive into them and learn things that's protected information but I can assure you that when cases come to our attention we—we get involved and we try to deploy the solutions at our disposal.

COUNCIL MEMBER KALLOS: So I've—I've the East Side Task Force for Homeless Outreach and

services. We've had extreme cooperation from the NYPD and the Department of Social Services. We have not had DOHMH respond to a request to participate, and I guess the question is what can DOHMH bring to the table for this individual so that we can get them the help that they need, and get them housing whether it's supportive or otherwise regardless of documentation status?

COMMISSIONER BASSETT: You know, I think you heard from Dr. Belkin that we usually don't comment on individual cases related to our desire to protect the privacy of individuals, but I—

COUNCIL MEMBER KALLOS: [interposing] In any type of case like what can we do?

COMMISSIONER BASSETT: --I can tell you if I could just finish with that we have open clear channels of referrals with both Homeless Services, Social Services, and we—and the hospital system. S o I would expect that the—that we would be engage in trying to assist any individual who had mental health issues who could benefit from the services that we have to offer.

COUNCIL MEMBER KALLOS: [interposing] So if I have somebody with a substance abuse issue or a

mental health issue, and they don't want to go to shelter, and they—we don't know their documentation status and—and we are a sanctuary city, you can make sure that they've got a supportive housing bed or other type of non-shelter bed to be in treatment?

COMMISSIONER BASSETT: I don't think I can guarantee housing for any one individual. It's not something that the Health Department has control over.

COUNCIL MEMBER KALLOS: And—and I guess the other piece is in response to the coverage today I'll actually be going with a constituent who was spat on by this individual they've—they have alleged to swear out a complaint at the 19th Precinct. At that point if there is a criminal charge brought, do you have any additional resources as DOHMH to provide assistance whether voluntary or involuntary?

COMMISSIONER BASSETT: [pause] Well, I—I really—I really don't think that we can comment on this individual case in this manner, but I—I—I do hear you that you're feeling that you aren't getting the support for this individual that you—that you feel the individual--?

COUNCIL MEMBER KALLOS: I—I—I have residents. I—I have folks who have substance abuse e problems who are homeless telling me that when they say okay I'm ready for rehab that there aren't rehab beds for them.

COMMISSIONER BASSETT: So there certainly are. I think you're talking about drug treatment services. There certainly are available drug treatment services in—in the city. We have available slots for drug treatment for people who have substance use disorders.

COUNCIL MEMBER KALLOS: So we—we have another gentleman who actually made the cover and that gentleman is—is reported as intoxicated and singing. So if that person says, you what, today I'm ready for rehab, you can guarantee me that they will have a—a spot in rehabilitation so that they can get that treatment?

COMMISSIONER BASSETT: It's—it's not clear to me whether in your mind rehabilitation implies in-patient care because there are many ways to be—enter substance use treatment that doesn't have to include in-patient care.

COUNCIL MEMBER KALLOS: Well, I—I think when you're dealing with severe situations where the people are--are publicly intoxicated multiple days a week that having in-patient as an availability, and on full disclosure I—I ran in-patient drug rehabilitation center. These are—I would probably recommend that we start off with in-patients so that we can get them to a place where they can be in an outpatient setting. So do we have the guaranteed inpatient beds that we need especially when it's really hard to help people with addiction when they don't have somewhere to sleep at night. There's—there's a Nationwide Housing first approach. So if we can't get them in-patient services or housing services, how do we get them the help that they need.

DR. GARY BELKIN: So, if jut lay some—some groundwork. So across the city we don't have a shortage of—of in-patient beds. The issue is can we match people in real time, and a lot of that is are the right people knowing when the need is there? So a lot of the outreach and teams that the Commissioner mentioned increase our ability as the Health Department to receive requests and to connect with both city agencies and other reporting agencies to

reach people like the folks that you're talking about. We've also made opportunities available, more easy opportunities for the general public to navigate their way in as well, NYC Well being one of those where a family member or somebody—it doesn't have to be the individual even looking for services that a family member, a concerned family member can call in and also be guided to navigate how to connect to—to a service. In the—in the case of individuals who are homeless, we have added capacity so we can reach people wherever they are. Some of the teams that the Commissioner mentioned allow us to follow people wherever they—wherever they go, and we are trying to work closely with the Department of Homeless Services. We had a whole hearing about a few months ago in terms of trying to plan together their capacity and build more safety net services to the—to that population.

COUNCIL MEMBER KALLOS: Would—would you join me the Eastside Task Force for Homeless Services Thursday, tomorrow morning at 10:00 a.m. Lenox Hill Neighbor House?

DR. GARY BELKIN: So, this is a not a—a meeting that we have otherwise been—heard about or

that I've heard about and we're happy to learn more about and to participate. We're always happy to participate in any kind of collaborative work to get these services to people and to get—be more responsive to connect people to care.

COUNCIL MEMBER KALLOS: And I just want touch on two other key issues. We've had numerous hearings about HPV vaccines. So you have a report on the number of children in our schools who have access and have received it and how many children haven't received the HPV vaccine?

COMMISSIONER BASSETT: Let me invite somebody up from either the Bureau of Immunization or School Health, but I know that we're working hard to promoted HPV vaccination among both boys and girls that we have rising rates of HPV vaccination coverage. I don't know about your specific question about a report. Dr. Daskalakas.

COUNCIL MEMBER KALLOS: The reason I ask is I've met with every middle school in my district and have the very fun and uncomfortable conversation about talking to principals and PTAs about how important the vaccine is.

COMMISSIONER BASSETT: Well, thank you. It is very important and it's a cancer prevention strategy.

COUNCIL MEMBER KALLOS: Right.

COMMISSIONER BASSETT: That's how I would recommend you talk about it.

COUNCIL MEMBER KALLOS: I—I—I—I do. However, I'm often cautioned about but our kids are too young to be sexually active, and I remind them that they might want grandkids, and they usually agree and [laughter] and we—we go into talking about where grandkids come from, and that you don't one without risk of the other. But that being said, there seems to be a gap where because administration happens in middle school and finishes in high school that a lot of times it's not happening. I don't have very many Title 1 schools in my district though I do have schools where I have 50% Title 1 children and they—Title 1 children are getting lost in the assumption that they go to school on the Upper Eastside so they must have access to a physician, and that physician must be providing them with a vaccine that can be quite expensive and may not be covered by

health—their specific health insurance without a large co-payment.

COMMISSIONER BASSETT: Let me ask Dr. Daskalakas. Does he-does he need to be sworn or can he just identify himself for the record. I'm not sure of the procedure here.

CHAIRPERSON JOHNSON: Do you swear or affirm to tell the truth and nothing but the truth to this committee and to respond honestly to Council Member Questions?

DR. DASKALAKAS: I do affirm.

CHAIRPERSON JOHNSON: Thank you.

DR. DASKALAKAS: So on the very specific question on HPV uptake, I'm looking at your report. What the uptake was for both first does and complete series for individuals age 13 to 17 years old, but I can't give you down to the sort a resolution of an individual school. It's the overall story in New York City and that answer is that for one dose of HPV vaccine as of December 31, 2016, 73.9% for females and 68.6% for males actually had the first dose and series completion, which obviously may lag behind since there is time between them. And 58.6% for females and 51.6% for males.

COUNCIL MEMBER KALLOS: That's a-a large drop-off. I'm interested in working with you to—to get that uptake up to 100%. If we get—lay off 99% and I guess one piece is with regards to these immunization records, you—are—does DOHMH based on the fact that children are receiving mandatory immunizations have information on the number of three-year-olds and four-year-olds and five-year-olds that are in the city of New York?

COMMISSIONER BASSETT: We have a—a children—an immunization registry in which we have information. I don't have that information for you now, but the main sort of gateway for mandatory vaccination is school entry, and that's where we have the tool, if you want to call it that, of school exclusion. So the child has to be vaccinated in order to enter school. So that's when we have the ability to take an action when a child hasn't been vaccinated. Otherwise, we learn about them in—when they're registered with our—in our immunization registry. I also wanted to note that—that the report that you're talking—that you mentioned that we will be providing is due for the first time in September of this year. So it's not done yet.

COUNCIL MEMBER KALLOS: And-and the last question. How much would it cost, and this is a budget hearing, to make our shelters no kill?

COMMISSIONER BASSETT: Well, we have the highest live release rate that we have ever accomplished in New York City. It's 89.2%. That's close to 90% and I would remind you that our shelters the Animal Care Center Shelters are the only shelters in New York City, which receive all—all pets, all animals, including some for whom the—the survival of the animal is—is not possible. So, I don't expect that we will achieve that, but we have—continue every year to have a higher and higher live release rate. That's a tribute to New Yorkers who have realized that our shelters are a wonderful place to adopt a pet, and it's a tribute to the hard work of the Animal Control Centers.

COUNCIL MEMBER KALLOS: Thank you and thank you, Chair.

CHAIRPERSON JOHNSON: Council Member Kallos and I are both cat owners.

COMMISSIONER BASSETT: I was, too, not recently.

CHAIRPERSON JOHNSON: And you got bit, right?

COMMISSIONER BASSETT: I love cats and dogs both. [background comments]

CHAIRPERSON JOHNSON: But you got bit by the feral cats that you adopted.

COMMISSIONER BASSETT: I had feral cats, but then the dog—

CHAIRPERSON JOHNSON: [interposing] And you got a bit.

COMMISSIONER BASSETT: --they hissed whenever they saw me. They didn't bite me. They hissed and were, you know, the data shows Chairman Johnson that having a pet is good for your life, and that people who own pets-

CHAIRPERSON JOHNSON: [interposing] Except when they hiss at you whenever they see you.

COMMISSIONER BASSETT: But if they hiss at you—

CHAIRPERSON JOHNSON: [interposing] We want to go to Council Member Salamanca.

COMMISSIONER BASSETT: --not a good thing.

COUNCIL MEMBER SALAMANCA: Thank you, Mr. Chair. Good afternoon, Commissioner. Commissioner, I wanted to ask and touch base in terms of back in February we had at 750 Grand Concourse a case of Leptospirosis, the issue with the rats. I know we had a meeting with the—we had a meeting with the tenants in the building. I know that that particular building is in what is called a rat reservoir. My question to you is what's that status in terms of addressing that rat reservoir, and how is the issue being remedied at the moment?

COMMISSIONER BASSETT: So I think there are two parts to your question. One is the state of the rate reservoir. That building is located in one of 15 rat reservoir areas in the Bronx, and the other is I'd like to update you on the state of that building. As you learned at the meeting, there were illegal conversions in the basement. People were living in the basement under terrible conditions. There were rodents in the basements. There we problems with garbage management, and with structural problems. Usually, we only see rats in buildings when there are structural problems, and that's a fancy word for saying there are holes and the, you

know, the walls have—don't have integrity. So, the rats can go through open holes from the outdoors, indoors. The building has been really cleaned up. We're working with HPD and the Department of Sanitation, which provided garbage bins in the basements. The structural deficits or the holes have been repaired and filled. We are continuing to be on site, and present and baiting. The tenants have been provided legal counsel as part of the Health and Human Resources or Department of Social Services' efforts to ensure that tenants have good legal representation. So I things in the building are much better. The idea of rat reservoir, though, is that you can't really get rid of rates in a building alone. That rats that become entrenched in the neighborhood need to be addressed on a neighborhood wide basis. The data that I can share with you for this area were—are in March of—of 2015 when the rat reservoir program just began, they go through the geographic area and the staff visit every lot, every building, every park looking for active rodent signs, and they found them in 35% of locations. When they went back recently, they found only half that number. So we aren't where we want to get yet, but we are—we

are definitely making progress. It's progress that depends on both on private owners, on city agencies, and on residents to achieve, and we are very hopeful that things are going in the right direction. So much better in the building, getting in the neighborhood.

COUNCIL MEMBER SALAMANCA: When was the last time that your agency was at this building and spoke to the tenants?

COMMISSIONER BASSETT: I'd have to—it's been—it will be weeks, but let me get the exact date for you. It might be days. [background comments] [off mic].

CHAIRPERSON JOHNSON: Do you affirm to tell the truth before this committee and to answer o Council Member questions honestly?

CORINNE SCHIFF: Yes.

CHAIRPERSON JOHNSON: Thank you.

CORINNE SCHIFF: Corinne Schiff, Acting Deputy Commissioner for Environmental Health and we have a case manager working in the neighborhood and working in the building as well, and I actually saw her yesterday. She was on her way to the building. She's there at least weekly and she was there

yesterday, and she described really a tremendous improvement at the building. She's monitoring very closely.

COUNCIL MEMBER SALAMANCA: Awesome. Commissioner, you mentioned that this location is one of 15 in the Bronx.

COMMISSIONER BASSETT: That's correct.

COUNCIL MEMBER SALAMANCA: Is the Department of Health planning on informing communities, the other 14 that they—those residents that they're living in a rat reservoir and dos and don'ts and what exactly you can do to avoid contacting disease?

COMMISSIONER BASSETT: Well, first, let me just separate that into a number of different questions. One is that we actively seek to work with community residents as part of rodent control efforts. We have something that's affectionately known as the rat academy, which I know several council members that may be the formal name, but it is the—it is actually a training program where you learn about how to identify active rodent signs and steps that you can take to reduce pest infestations. These are available training programs. I know

several council members and the Borough President's office has hosted these trainings, and we'd be happy to follow up with you on that. You asked about Leptospirosis, and I do want to point out that this an extremely rare disease. We see a handful of cases every year. It's related to rodent urine, and in our setting principal—that's the principal source, and the situation that we encountered in this area where we identified a cluster for the first time was—had a set of unusual circumstances. This is very rare. It's not caused by rat bites or touching rats. It's—it's spread through rat urine, and there are a lot of rats in New York City. We're working had to reduce their number, but Leptospirosis remains very rare.

COUNCIL MEMBER SALAMANCA: But Commissioner, are you willing—or is—are you willing—is your agency willing to publicly identify the other 14 locations?

COMMISSIONER BASSETT: Oh, they are. As far as I know, they are publicly identified. We have 45 around the city.

COUNCIL MEMBER SALAMANCA: Okay.

COMMISSIONER BASSETT: And there are 15 in the Bronx, and we'd be happy to give you the coordinates.

COUNCIL MEMBER SALAMANCA: Are any of these locations, these reservoirs in NYCHA developments? Because I'm speaking to my tenants--

COMMISSIONER BASSETT: [interposing] The answer to that is yes.

COUNCIL MEMBER SALAMANCA: Alright.

COMMISSIONER BASSETT: And we also work directly with NYCHA on pest management, and—and give them support in—in pest management. You—I—you were going to say that you think NYCHA developments have a problem with pest management?

COUNCIL MEMBER SALAMANCA: Oh, they do. I mean you—you cannot walk through a NYCHA development at least in my council district without somebody with a rat, you know, running around in the grounds. So, we'd love to really sit down with your agency to see if I have other reservoirs in my Council District, but really focus on 750 Grand Concourse on addressing their issues. I have—just have two more questions. Family planning. You know, in my life before getting into government I was

healthcare administrator. I have a passion in terms of protecting the rights of our adolescents and just families in terms of family planning, and I'm concerned about the potential cuts in Planned Parenthood that this new federal government is—will have on—and what is the city doing? Should there be cuts in family planning and Planned Parenthood to ensure that the—these agencies and these services are—are protected within the City of New York.

COMMISSIONER BASSETT: Well, I'm really glad to have a family planning advocate, and someone who will work directly in that area in our City Council the cuts to Title 10 and the threats to Planned Parenthood are a source of great concern to us, but I think we all saw last week when the efforts to repeal the Affordable Care Act were turned back in the house that it is possible to resist these efforts, and that is our goal. We also have worked in schools to make access to contraception a possibility through our school based health clinics, and through school and also through--in schools where we don't have school based health clinics. So it remains an important human right I would argue for women to have access to not just information about

the contraception, but the actual contraceptive services, and we are continuing to make that available. We'll continue to endeavor to do that.

COUNCIL MEMBER SALAMANCA: Right. You can count on me to be a partner in protecting--

COMMISSIONER BASSETT: [interposing] Thank you.

COUNCIL MEMBER SALAMANCA: --Family Planning Services. Lastly, the undocumented in terms of the HIPAA Law. You know, we have the undocumented community that goes to see a provider. Most of them are uninsured and so they're put on the sliding fee scale. You have HQHCs who, you know, cannot turn anyone away regarding their inability to pay. Does HIPAA Law protect the undocumented in terms of the federal government having access to the medical records or having access to individuals that are uninsured to see if they're documented or undocumented, and just to personal information?

COMMISSIONER BASSETT: I—I should—I should think that it does, but you are aware I'm sure that the—that there's an executive order that we cannot in any—in any of our services or in any healthcare facility ask information about people's

documentation status. So we don't do that at the Health Department. We protect people's private medical records, and I would expect that that is covered. Do you want to comment?

COUNCIL MEMBER SALAMANCA: You know, the reason I asked is because for example I have a two-year-old and when we took him to the doctor the asked for certain documents, a birth certificate being one of them, and we needed to show that so even though mom and day, my wife and I would go to the doctor just to—if I were to go on my own just to prove that hey, he's really with dad and this—this really happens.

COMMISSIONER BASSETT: [interposing] Well, they're checking their medical records.

COUNCIL MEMBER SALAMANCA: [interposing] So if you have a child that comes in and doesn't have doesn't have a birth certificate on file, that's an avenue where if the federal government has access to the medical records or try to draw their attention to that family.

COMMISSIONER BASSETT: I—I'm sure that we don't ask people for their birth certificates, and

I'm—I'm not sure why you were asked for it but I have had--

COUNCIL MEMBER SALAMANCA: [interposing] That's—that's one of the requirements to my understanding when you go to—when you go to at least to a—a medical provider, and you bring a child they want proof.

COMMISSIONER BASSETT: They want proof that you're the parent?

COUNCIL MEMBER SALAMANCA: Yes.

COMMISSIONER BASSETT: Is that what they're after?

COUNCIL MEMBER SALAMANCA: Yes.

COMMISSIONER BASSETT: Well, let me—let me turn this question over to our General Counsel. He's a lawyer.

COUNCIL MEMBER SALAMANCA: [interposing] I'm sorry. I see your staff is shaking their head. So that's not a requirement that you have to provide a—a birth certificate to prove that you're the parent?

COMMISSIONER BASSETT: I—I, you know, I—I—this is—I have never been asked to do this, and I'm a parent, and I don't know anybody who's been asked

to prove that they are the parent of a child that they bring to a facility, but I—I absolutely am not question questioning your experience. So let me turn it over to the lawyer for the Health Department.

THOMAS MERRILL: Do I--do I need to be sworn in? Thank you.

CHAIRPERSON JOHNSON: Yes. Do you swear or affirm to tell the truth and nothing but the truth to this committee, and to respond honestly to Council Member questions.

THOMAS MERRILL: I do.

CHAIRPERSON JOHNSON: Thank you, Tom.

Council Member, I'm Thomas Merrill. I'm the General Counsel for the agency, and so to your question about HIPAA—HIPAA. HIPAA finds the medical records so regardless of whether you're documented or not it would apply and it would protect the records of treatment. There are exceptions within HIPAA that allow disclosures and one of the—you know, so it—so I think when get theoretical here in terms of and how the requests would come, but there are—if something is mandated by law, it would have to be just turned over regardless if you're documented or not. So depending on how the request came in from the federal

government there might have to be turned over, but HIPAA does protect all records regardless. It's not specific to documented or undocumented.

COUNCIL MEMBER SALAMANCA: Now, in regards to—I just want to go back to that birth certificate because—

THOMAS MERRILL: The birth certificate for that. (sic)

COUNCIL MEMBER SALAMANCA: --I envy the—the two agencies that I worked with as healthcare administrator I remember that being a requirement, and I remember DOH coming in and doing audits, and you—you know, they wanted to ensure that a child had proper documentation and birth certificates was one of them. So you're saying that that's not a requirement?

COMMISSIONER BASSETT: No this would be the other Health Department, the State Health Department. They have oversight over healthcare facilities. I don't have oversight over healthcare facilities. So I don't want to pretend that I'm familiar with those regulations. So I'm just speaking out of experience—my person experience, and I—I wouldn't question the experience that you have.

I do understand that you are concerned that people not be made vulnerable with respect to their documentation status when they seek care. And I can assure you that in the Health Department services we do not request and would not pursue any information on a person's documentation status as a requirement for services.

COUNCIL MEMBER SALAMANCA: Alright, well thank you, Mr. Chair. Thank you.

CHAIRPERSON JOHNSON: Thank you, Council Member Salamanca. So, I want to get back into the childcare inspections and homelessness issue that I was talking about before--

COMMISSIONER BASSETT: [interposing] Sure.

CHAIRPERSON JOHNSON: --I called on my colleagues. Would the Administration support changes to Article 47 of the City Health Code to include childcare centers in city shelters?

COMMISSIONER BASSETT: We are in discussions with the Department of Social Services about the whole issue of childcare in shelters. Obviously, if it's a childcare center, it would need to be regulated by the Health Department.

CHAIRPERSON JOHNSON: So you're open to it?

COMMISSIONER BASSETT: We're having conversations, and we're figuring it out.

CHAIRPERSON JOHNSON: Which means you're open to it.

COMMISSIONER BASSETT: I guess so. [laughs]

CHAIRPERSON JOHNSON: Okay. A recent study found that New York City's homeless high school students faced serious health risks including asthma attacks, unplanned pregnancies and self-harm. What is the department doing to work with the Department of Education, the Department of Homeless Services to better serve this vulnerable population?

COMMISSIONER BASSETT: I'm not familiar with the study that you're citing, but I do know that we have a very robust school health service in our schools. It's one that has grown enormously in this administration, particularly with respect to the ability to offer behavioral health services, which should—it sounds like it might have a role to play with children who are coming from homeless shelters. The observation that these are vulnerable children is

certainly true. The fact that we have school based health clinics where—in 150 schools is an opportunity obviously to provide full service primary healthcare to children, all children, homeless or not, and an important resource for these children. We also have worked now for some years on better management of asthma care in schools. So, I can't say that we have a specific program aimed at children in schools who are homeless. We have a very robust school health program that aims to serve all the children in our schools.

CHAIRPERSON JOHNSON: Great. I want to talk about food safety.

COMMISSIONER BASSETT: Uh-huh, you--

CHAIRPERSON JOHNSON: The Fiscal 2018 Preliminary Plan allocates more--

COMMISSIONER BASSETT: [interposing] Hang—hang on one second. Dr. Askew is the Deputy Commissioner for Family and Child Health. He wants you to know more about asthma in schools.

CHAIRPERSON JOHNSON: Sure.

COMMISSIONER BASSETT: I think.

CHAIRPERSON JOHNSON: Great, great.

COMMISSIONER BASSETT: Well, I want you to meet my wonderful team.

DR. GEORGE ASKEW: [interposing] Yeah, I know.

COMMISSIONER BASSETT: We do have a fabulous team.

DR. GEORGE ASKEW: [interposing] No, I'm happy—I'm happy to introduce to them.

COMMISSIONER BASSETT: Yes.

CHAIRPERSON JOHNSON: I'm glad he's here.

COMMISSIONER BASSETT: Do you swear or affirm to tell the truth and nothing but the truth to this committee and respond honestly to Council Member questions?

DR. GEORGE ASKEW: (off mic) I do.

CHAIRPERSON JOHNSON: Thank you very much.

DR. GEORGE ASKEW: Now I'm on. No, George Askew, Deputy Commissioner for the Division of Family and Child Health for the Office of School Health lives in conjunction with our colleagues at the Department of Education, and I didn't want to add much. I just wanted to say that we are looking very specifically at schools where there's high

percentages of children who are homeless or—or inadequately housed, and so we're looking at putting additional services specifically into those—into those schools.

CHAIRPERSON JOHNSON: That's great. I mean there a story in the New York Times today about I believe it was a school—it is may not be—either Brownsville or East New York where I think 30% of the kids are kids that are currently homeless, and the efforts of the Department of Education has been making and the schools have been making to get them better test PREP, meals, all sorts of things to support their development given their unstable housing situation. So, it's great to hear that—that the Health Department is going to be working or is working with DOE on these issues.

DR. GEORGE ASKEW: Great.

CHAIRPERSON JOHNSON: Thank you.

COMMISSIONER BASSETT: [off mic] Thank, George.

CHAIRPERSON JOHNSON: It's good to meet you. So we're going to talk about food safety. So the Fiscal 2018 Preliminary Plan allocates more $17 million to the Bureau of Food Safety and Community

Sanitation. A 2015 City Controller audit determined that the bureau needed to strengthen its controls to ensure that food service establishments resolved health code violations in a timely manner. The audit also found the Bureau of Supervisors failed to consistently perform supervisory field inspections at the level established by inspection procedures. How has the department responded to the Controller's Report?

DEPUTY COMMISSION SCHIFF: Well, so I'll take two things. One in terms of follow-up on the repeat inspections we do provide the—the inspection results to the restaurants so they know what it is that we have found. We've launched a new program called a Inspection History Report, and it's really interesting report where we—we provide the restaurants with three years of data. So they can really see repeat violations and try to make more long-term changes in their programs. In terms of the closure issue that the Controller noted for us, we did make a change so that when whatever decision is made by the Bureau about closure, it's recorded in our data system where we—where the determination is to close or not to close the restaurant. The

inspector makes a recommendation. That decision is not made by the inspector. It goes to a supervisor and then to the supervisor's supervisor. So there's a lot of review there and we changed our system to record all of that.

CHAIRPERSON JOHNSON: So the Food Service Establishment Advisory Board's 2016 Annual Report recommended nine changes to the restaurant inspection grading process. Most of these recommendations were that DOHMH stop counting certain violations towards a restaurant's letter grade as it did not pertain at all to food safety. The Board's report stated these changes "balanced the need to protect public safety while not excessively penalizing food service establishments for non-critical food violations. However, DOHMH recently responded to these recommendations with a statement modifying or rejecting six of the proposed nine changes. Why did DOHMH reject so many of these recommendations? This Advisory Board includes experts in food safety.

COMMISSIONER BASSETT: So let me start and then I'll ask Acting Deputy Commissioner Schiff to come in. The Food Service Establishment Advisory Board has been a very useful addition to the Health

Department. We met throughout last year and met just last week at which time some of the recommendations that the—had been made by the Advisory Board were reviewed and considered and as you note, not all of them were accepted. Some of them were. I—this issue really relies—revolves around the adjudication of letter grades. As you are aware, something like 92% of our restaurants or 24,000 of them put up an A letter grade, a highly valued letter grade, but only 62% of these restaurants achieved that letter grade on the initial inspection. The rest of them go through a process in which a letter grade is adjudicated, and we continue to stand by the fines that we have—we have issued related to the initial inspection. I would note for the Council that the income from fines is not—is now about at a level that it was before letter grades were ever introduced. It's been a huge decline from a—a maximum. I's something over $50 million a year down to now about $21 million a year. So most of the has been due to the fact that we have an all-time high of people getting A letter grades. Do you want to add to that?

DEPUTY COMMISSION SCHIFF: I can just say that we met with the subcommittee of the Food Service

Establishment Advisory Board. The Board created a subcommittee to address the issue of violations, which is something they were mandated to review under the local law that established the committee. We had very productive discussions with them. They presented—it may have been a little more than nine. It was more like ten violations. Their recommendations were not necessarily to remove them from the scoring system. For the most part, I don't think they said they were not related to food safety, but they requested certain changes in them, and there were many that we were able to accept exactly as the Board presented them to us. Some of them we made other kinds of changes trying to get at the concerns that the Board raised, but trying to address those in a slightly different way. Some of them, as you say, we did not think were in the best interest of public health, and we laid out for the Board our—our reasoning there. We'll now be moving into rulemaking. So there will be opportunity for-for further comment because that was sort of our—our process in our thinking.

CHAIRPERSON JOHNSON: So, if there is a food service restaurant or establishment that in the

public bathroom there is not the appropriate sign that's supposed to be hung up that says something like you're supposed to wash your hands—

COMMISSIONER BASSETT: [interposing] If you're an employee, wash your hands. Yeah.

CHAIRPERSON JOHNSON: Which they should have. I'm not saying they shouldn't have that. I don't understand why that counts towards a letter A. Why does that count towards a letter grade?

COMMISSIONER BASSETT: I think hand washing is really a core sanitary behavior.

CHAIRPERSON JOHNSON: No, what I'm saying is there are—okay, let's take a dented can. There's a dented can and an inspector comes in and finds a dented can with the other dented cans, and they're not separated out as they're supposed to be under the law. Why should that count towards their grade?

COMMISSIONER BASSETT: The problem with dents in a can is it may imply an integrity problem with the packaging of that item. So, that's why we're concerned about dented cans. Do you want to add to that?

CHAIRPERSON JOHNSON: So the point I'm trying to make is that I think that there are plenty

of things that are in the rules right now that are a stretch to pertain to the actual letter grade of a restaurant.

COMMISSIONER BASSETT: So what the letter grade is really aimed at measuring not the healthfulness of food, but the sanitary practices that underlie its preparation. That's what it's about, and we're very confident that we've made a lot of progress in improving sanitary practices. When I first started, a quart of restaurants, a quarter were reporting that they had mice. That proportion has gone way down, and many other types of violations have gone down. So we're confident that the letter grading is not in anyway trivial as a way of enhancing hygienic practices in restaurants.

CHAIRPERSON JOHNSON: I support a letter grade system. I support a saner letter grade system.

COMMISSIONER BASSETT: But I would beg to differ. I think it's quite sane.

CHAIRPERSON JOHNSON: I—well, we're going to have a hearing on this.

COMMISSIONER BASSETT: Be open for public comment and we'll have something to say. (sic)

CHAIRPERSON JOHNSON: [interposing] Well, we're going to have a hearing on this with legislation in the next couple of months because I think that the current system—I support a system. I think there should be grades, but if you get a certain number of points with this and now a number of points for this, and if you have less than 16 points you get an A. I mean you need like a degree to understand how the letter grade system works. I mean it's crazy. Other cities—we're the only city—if you go to Los Angeles, which my understanding is the previous Administration looked at L.A.--

COMMISSIONER BASSETT: [interposing] That's correct

CHAIRPERSON JOHNSON: --and the letter grade. Our letter grading system looks nothing like their letter grading system.

COMMISSIONER BASSETT: Well, this is New York City. [laughs]

CHAIRPERSON JOHNSON: Well, they're—theirs seem a lot more sane to me where there's 100-point scale. You know, if you get above 90 you get an A. We have this bizarre system where if you get a certain—under a certain—we're not going to litigate

it here today, but we're going to have legislation on this because I don't think the system makes sense currently. I think that it needs to be in a more comprehensive and fair way, and that it can be done while still protecting the integrity of customers, and New Yorkers as it relates to food safety and sanitary conditions, but in a way that makes more sense for business owners, and for the public to understand. If you ask—if you walk down the street and asked most New Yorkers how does a restaurant get an A, they couldn't tell you because it is extremely hard to understand how you get an A, how you get a B, how you adjudicate all of these things. I think that the—and this is not a criticism of you. That is not a criticism of your team unless they were the ones that were there that implemented the system. That—that when the system was set up, it was set up in a very imperfect way, and I think that we can build on it, make it fairer, make it more easily understandable while still protecting the integrity that we want to have as I relates to pest and vermin and Salmonella and all of the flies and all of these things. Talk to any small business owner right now, and they'll tell the system is broken.

COMMISSIONER BASSETT: We'll talk with you about this, and I'm glad that you support letter grading--

CHAIRPERSON JOHNSON: [interposing] I support it.

COMMISSIONER BASSETT: --and I think New York City residents have voted with their feet, and owners cover their A letter grades. That's exactly what we hope to accomplish.

CHAIRPERSON JOHNSON: We—we can get into the nitty gritty when we meet or when we have a hearing on this, but I think the adjudication process needs to be changed on when things go to OATH. I think there's a whole host of changes that need to be made.

COMMISSIONER BASSETT: We're happy to talk with you.

CHAIRPERSON JOHNSON: [interposing] I've—I've studied this a lot. I've looked at it. I mean I'm—I think that the system is replete for significant changes and modifications that will maintain the integrity that make it a fair, more easily understandable system. I don't know how the system was adopted like this in the first place. We

should be more like Los Angeles and less like the system we have right how. So I look forward to working together.

COMMISSIONER BASSETT: Absolutely.

CHAIRPERSON JOHNSON: We're probably going to disagree.

COMMISSIONER BASSETT: I think we may, but we will all look forward to ensuring that dining in New York City remains a wonderful and healthy experience and hygienically safe experience that it is.

CHAIRPERSON JOHNSON: And in a way that the public can understand.

COMMISSIONER BASSETT: I think they understand A, B, C. [laughs]

CHAIRPERSON JOHNSON: They don't understand what it means to get an A, B or or a C.

COMMISSIONER BASSETT: We will talk, and I look forward to the conversation.

CHAIRPERSON JOHNSON: See, when we talk to kids and we say like the ABCs, that's supposed to be like—the ABCs are like the most easily understandable things. This system you could go MIT

and ask them how do you get an A, and they'll say well, you know, dented cans and—I mean it's bizarre.

COMMISSIONER BASSETT: Well, we do know that our As do predict them. They have a real bearing on—on sanitary safety. So we'll look forward to talking. We have a lot of data that we'd be happy to share with you.

CHAIRPERSON JOHNSON: I want significant changes to this system, and I'm going to push for them. Thank you. Okay, so let's get to HIV and AIDS. So Dr. Varma who used to be the Deputy Commissioner for Infectious Diseases is now in Africa.

COMMISSIONER BASSETT: I'm not sure he's quite there yet, but he's headed there.

CHAIRPERSON JOHNSON: He's heading to Africa, and so right now we have as the Acting Commissioner for Infectious Diseases Dr. Daskalakas, who oversaw the HIV and AIDS Bureau and still does.

COMMISSIONER BASSETT: That is correct, although there is an acting for the HIV and AIDS Bureau being the Deputy and for Disease Control is a pretty busy job.

CHAIRPERSON JOHNSON: But he's, but Dr. Daskalakas is the Acting right now.

COMMISSIONER BASSETT: He's acting right now.

CHAIRPERSON JOHNSON: And how long has he been acting for?

DR. DASKALAKAS: [off mic] February 10th.

COMMISSIONER BASSETT: February 10th.

CHAIRPERSON JOHNSON: Since February 10th. So it's only been a month and a half.

COMMISSIONER BASSETT: That's correct.

CHAIRPERSON JOHNSON: And then when will the decision be made on who—who gets the--

COMMISSIONER BASSETT: [interposing] Very soon.

CHAIRPERSON JOHNSON: Well, I hope it becomes Dr. Daskalakas.

COMMISSIONER BASSETT: Well, I appreciate that vote of confidence.

CHAIRPERSON JOHNSON: And he didn't know I was going to say that [laughter] but he has done an incredible job, incredible, incredible.

COMMISSIONER BASSETT: I am very lucky to have a very strong leadership team. We have a great tem.

CHAIRPERSON JOHNSON: [interposing] Well, if he can do in infectious disease, what he's been able to do for HIV and AIDS with advocates and with New Yorkers--

COMMISSIONER BASSETT: [interposing] Yeah.

CHAIRPERSON JOHNSON: --and with the City Council and with health institutions across the city of New York that he's done—he didn't know I was going to say this. He and I haven't talked in months.

COMMISSIONER BASSETT: Sure. [laughs]

CHAIRPERSON JOHNSON: That, you know, you'd be very well suited. I know you're a fan. I know you appreciate his leadership, but I think he would do a fantastic job and I want to talk about that good work now at it relates to HIV and AIDS. Ok. So the Preliminary Budget allocates $191 million to the HIV and AIDS Prevention and Treatment Bureaus, which is a decrease of $5.5 million, about 3% when compared to the budget at adoption. The funding reductions occurred primarily in contractual

services. It was what we were talking about earlier, contractual services, and getting these contracts out. The plan reduces that program's headcount by 18 positions. What specific programs and services will the headcount and funding reductions affect?

COMMISSIONER BASSETT: I'm going to—I'm got asking Sandy Rozza to go first, and—and then we'll turn it over as needed.

DEPUTY COMMISSIONER ROZZA: So on the—on the headcount, the 18 is actually just grants, the grant adjustment in bringing the awards down in line with the headcount. There were no actual reductions. It's just the bookkeeping to make sure that--

CHAIRPERSON JOHNSON: So there is nor real reduction?

DEPUTY COMMISSIONER ROZZA: In the headcount.

COMMISSIONER BASSETT: In the headcount.

CHAIRPERSON JOHNSON: The $5.5 million that you refer to in the contractual, most of that was just again another bookkeeping shifting. I do have funding for the Bureau of HIV into our Mental Hygiene Division under the—the cut, the Bureau of—what? [background comments]

COMMISSIONER BASSETT: Alcohol and Drugs.

CHAIRPERSON JOHNSON: Okay.

COMMISSIONER BASSETT: We have some, too.

DEPUTY COMMISSIONER ROZZA: So again, it's primarily bookkeeping.

CHAIRPERSON JOHNSON: Okay. So, starting on August 29, 2016 all New York City residents with HIV and AIDS who meet the financial need requirements are eligible to receive HASA services, and we had a hearing with Commissioner Banks a few days ago where we've seen I think the number is almost 18,000 new people have enrolled and who now get benefits to provide stable housing and rent—rental assistance for themselves. What kind of collaboration has occurred between DOHMH and the New York City Human Resource Administration regarding HASA services?

COMMISSIONER BASSETT: Well, I—as you know, we have worked closely with—with Department of Social Services on the End the Epidemic effort. The availability of housing is a key resource to people who are living with HIV-AIDS. We have very good data for both HASA and HOPWA that people who are stably houses have lower viral loads and more participation in their care. So I would describe it as a very

close collaboration, one that began with the planning process for the End the Epidemic.

DR. DASKALAKAS: Additionally, we are working closely with HASA to become the trainers for individuals who will be doing outreach in HASA housing, for individuals who are not priority suppresses to case management and bring them back to care or to care. So the Department of Health is going to be mentoring in effect the case management aspects of HASA that have been supported by Council.

CHAIRPERSON JOHNSON: Great. So I don't want to nitpick here, but I'm here and I'm going to ask a few--

COMMISSIONER BASSETT: But we—we're happy to accept those questions and—and address them if you have a--

CHAIRPERSON JOHNSON: [interposing] No, I—I have more questions--

COMMISSIONER BASSETT: Okay.

CHAIRPERSON JOHNSON: --and this is not me, it's—it's just continuing to build on the good work we've done. So we've had major investments that we've talked about [coughs] and programs to ending the epidemic and other initiatives that you all have

done a great job on. The target of 92% of patients enrolled in Ryan White where the current anti-retroviral prescription right now it's just below 90% The goal is 92%. I think we're doing really well, but how do we get that number up even higher?

DR. DASKALAKAS: So I think that there are a lot of elements that are working simultaneously in New York City to support that, and a lot of that does evolve around ending the epidemic. I think that with increasing efforts to mix it into retroviral therapy faster on the re-diagnosed individuals that may be what makes the difference with that margin. So one fantastic example was the work that's happening currently in the sexual health clinics where individuals, and now I think it's three—three clinics who are diagnosed with HIV are actually offered therapy on the same day, and so far the update given the fact that it's only been in three clinics has been remarkable. So I think that one answer is that we're encouraging significant work to get people antiretroviral therapy faster because we know from other cities that the data indicates that those individuals tend to stay in care and stay on anti-retroviral therapy, So in effect, New York City

is treating HIV like an infection, which is the right answer and not delaying, and I think that will change the numbers.

CHAIRPERSON JOHNSON: So the department's new Jump Start program provides antiretroviral treatments in connection to care to patients who are newly diagnosed with HIV. I know you've worked very hard on this program, and you should be very proud of it. The program is currently available at the Riverside, Fort Greene and Jamaica Sexual Health Clinics. What is the timeline for providing Jump Start all eight STD clinics?

DR. DASKALAKAS: So Sue Blank is the Assistant Commissioner for the Bureau STD, flashing number five to me just now, which means that Jump Start is at five of them, and so we have three left, and I think that we're looking probably by the end of the year to have all the Jump Start facilities on board.

CHAIRPERSON JOHNSON: Probably the end of the year or by the end of the year.

DR. DASKALAKAS: By the end of the year we will be on board.

CHAIRPERSON JOHNSON: And you received—I believe the department received $500,000 grant from the MAC AIDS fund. What was that grant for and how has it been used? [background comments]

DR. DASKALAKAS: So, just—so they actually were part of the initial launch of Jump Start at the Riverside Clinic. So the use of private funds actually facilitated the speedy initiation of Jump Start at Riverside. So they were—they were involved really at the ground level of getting that started at the first clinic, and then subsequently everything has launched using the Ending the Epidemic Funds, and further support is happening at Riverside using the Ending the Epidemic Funds. So they were really the first step in making this happen very quickly.

CHAIRPERSON JOHNSON: So Dr. Daskalakas, there has been a lot of research that's come out recently, though. You probably have the most up-to-date information on this that continues to show that an HIV positive person who is virally suppressed who is on their medication, taking it everyday, and is undetectable, as it relates to the virus, and their body that what I read recently is that there is

almost a zero percent chance that that an individual who is virally suppressed can actually transmit the virus to someone else. Is that the most up-to-date information the department is operating off of?

DR. DASKALAKAS: The answer is yes, and I'm actually also proud if you know—if you haven't seen this to tell—to remind you that New York City is the first jurisdiction in the United States to sign onto a consensus statement that affirms that statement. So we are the first city or state.

CHAIRPERSON JOHNSON: And Dr. Bassett, what happens if the—if the cuts that we talked about earlier are not, you know, $100 million to Ryan White but if they're $25 million, and we disproportionately get hit because we have the highest number of people living with HIV and AIDS in the United States in New York City. What happens then?

COMMISSIONER BASSETT: Well, I—I think that we have a high degree of political commitment at both the state and city level to ensuring that we embed the activities that have been addressed—adopted under End the Epidemic. There would be an effort to protect these services. You've heard about some of them but it is a whole portfolio of services that

includes making 28-day PEP available. That's now at all eight of our clinics, making PREP available and, of course, we are serving a population that is not well served in other settings through sexual health clinics. We know that we have an epidemic here in New York City that is predominantly affecting men who have sex with men, predominantly affecting Black and Latino men and often affecting young men, and that is exactly the group of people who we see coming through our clinics. So it will remain just critical and it's good public health protection not only for the person who is living with HIV, but for—in terms of ending transmission of HIV. So I'm very optimistic that we'll be able to be protect this—this investment because it makes such good public health sense, and New York City is being looked to not just across the country, but around the world as a—as an example of how to tackle HIV in an urban setting.

CHAIRPERSON JOHNSON: I'm going to go to Council Member Koo who has a question.

COUNCIL MEMBER KOO: Thank you. Thank you, Chair. Thank you, Dr. Bassett, and my question on the restaurant inspections how often are you supposed to do it?

COMMISSIONER BASSETT: There's one unannounced inspection for every one of our 24,000 restaurants in New York every year.

COUNCIL MEMBER KOO: Every year.

COMMISSIONER BASSETT: And it's unannounced. The reason that it's unannounced is so that we, you know, see what their management is like in the absence of advanced warning. When a restaurant is starting out, they may request inspection. It's like a practice inspection and any restaurant that—and that we make available at very low cost. It may be free, and if you are an existing restaurant and you want to practice inspection, and you've already had inspections, it's available at a—at a reduced cost. Certainly, $100, much less than the private sector. The other inspections are follow-up inspections to make sure that any problems that were identified were—have been attended to. So it's one unannounced inspection a year.

COUNCIL MEMBER KOO: So suppose a restaurant receive a low grade. In other words a B or lower. Your grade, right? They—how often your agency will go back to inspect the restaurant again? Because I see some restaurants with the low grade for

a long, long time like six months or something like that, yeah.

COMMISSIONER BASSETT: Yes.

DEPUTY COMMISSION SCHIFF: So department established a risk based inspection schedule and so restaurants that perform poorly on inspections are inspected more frequently than restaurants that perform well. So a restaurant that gets an A grade on its initial inspection we will not be back for year. If a restaurant doesn't get an A, then we come back for that repeat inspection that Dr. Bassett was mentioning. We do that in about 30 days, and that's the graded inspection, and that's where the restaurant can post a grade or a grade pending sign. You may see sometimes the grade pending sign. We look at those two inspections, the initial inspection and that follow-up inspection and we look at the scores of those inspections, and that's how we determine the next inspection for that restaurant. So a restaurant that has C on that re-inspection or has gotten in the C range on either of the two inspections we'll be back in about three to five months roughly and a restaurant that's in that B range, it will be more like seven to nine months, and

again the restaurant that best scores the A, we won't be back for a year.

COUNCIL MEMBER KOO: Okay. [coughs] What about hose food counts? Do you ever use bad food counts kind of annually. (sic)

COMMISSIONER BASSETT: Yes, the food carts are also inspected annually.

COUNCIL MEMBER KOO: How—how often?

COMMISSIONER BASSETT: Once a year.

COUNCIL MEMBER KOO: Once a year. How do you indicate this particular food count? This inspected?

COMMISSIONER BASSETT: Well, in order to be licensed, they have to be inspected. So all—all of our licensed food carts have been inspected, but we have been in conversations about how to make this information more available to the public.

COUNCIL MEMBER KOO: Because this—this inspection and the registration on a food cart is like—usually good for two years or three years. You cannot tell by looking at that you—you inspected the cart?

COMMISSIONER BASSETT: You're correct. We are in discussions about ways to make the

inspection results, which are performed annually more available. I can ask Deputy Commissioner Schiff to say something about what our inspection results are like. The—the food carts are doing pretty well, and I also want to mention to you that when you get a C grade it—it doesn't mean that your food is unsafe. We don't allow restaurants that have unsafe practices to continue to be open for business. It just is not, you know, just like you don't get kicked out of school or asked to repeat the year for a C grade. It just is not a great grade. Do you want to say something?

CHAIRPERSON JOHNSON: But I mean you may have too many dented cans.

COMMISSIONER BASSETT: [laughter] I don't know about you and the dented cans.

COUNCIL MEMBER KOO: So no, no, no-

CHAIRPERSON JOHNSON: It's insane. Sorry Council Member.

COUNCIL MEMBER KOO: No, my—my question is on the food count in all restaurants?

COMMISSIONER BASSETT: Well, I wanted to ask Corinne Schiff to say something about what our inspection findings are because they're generally

pretty good, but you are pointing out that it doesn't—it's not available readily to the public what these inspections show.

COUNCIL MEMBER KOO: So do you support the—the Council legislation for putting a grade system on food counts in the same thing like restaurants? Do you support that?

CHAIRPERSON JOHNSON: Council Member Koslowitz has a bill to have letter grades of food carts.

COMMISSIONER BASSETT: [interposing] Yeah, I haven't read your bill, Council Member, but we do have concerns that I expected then relayed to you about the whole issue with the mobile food service establishment and—and putting a physical letter grade on it.

COUNCIL MEMBER KOO: Because I think that is really necessary because sometimes when I pass food carts they—like the workers they smoke and they cook together, no, and sometimes they leave all the stuff on the road—on the street. So it's important that we have some like expression and grading so that customer know which carts are good to use and which carts are not good.

COMMISSIONER BASSETT: Your-your point is well taken that we are all in favor of transparency as information about our inspections and we are in discussions about ways to accomplish that because we have to get more complaints.

COUNCIL MEMBER KOO: [interposing] Because you have to get more complaint drive, right? Suppose nobody call about a particular food cart, no. It's not going to get inspected.

DEPUTY COMMISSION SCHIFF: Our inspections are not—we do respond to complaints, but we do also have routine inspections. So it's complaint driven, but also there are routine inspections, and—and we're—we're looking into this, too, transparency. We agree with you that—that we could expand transparency.

COUNCIL MEMBER KOO: Okay, thanks.

CHAIRPERSON JOHNSON: So in concept do you support letter grades for food carts.

COMMISSIONER BASSETT: I—I have some concerns, but I do support the idea of the public being aware and some grades—

CHAIRPERSON JOHNSON: So letter grades are good enough for restaurants, but not for food carts?

COMMISSIONER BASSETT: It has to do—I'd be happy to have this conversation at a—a greater length with you, but it has to do with concerns about the fact that it's harder to keep track of a mobile unit than it is to keep track of something that is stationary because it's brick and mortar. So we are committed to having transparency. We also are very—very serious about maintaining the integrity of our letter grading. We want it always to be appropriate to the food service establishment. So we have some concerns that we'd be happy to talk with anybody who wants to hear them, and I know that there was a lot of concern about letter grades when they were first introduced for restaurants and it's encouraging to me that—that they're not so sought after.

CHAIRPERSON JOHNSON: Would you support siting of food carts so you would know where they would actually be?

COMMISSIONER BASSETT: You know, that's—so far our licenses have, you know, been unrestricted. The ones that are unrestricted people

aren't given assigned spaces. That is not something that the Health Department has involved itself with. Our—our role with respect to the inspections of—of mobile food vending is to ensure that the food is prepared in a hygienic fashion. There are obviously other issues around what people root is, but people who have a mobile food license unless they're one of the ones that limited to a—a borough, they are allowed to go where they want.

CHAIRPERSON JOHNSON: What about GPS? Would that help?

COMMISSIONER BASSETT: Well, that would certainly, you know, tell you where the place was. That raises a lot of concerns that some people have about the intrusiveness of government and perhaps is worth a longer conversation.

CHAIRPERSON JOHNSON: Okay. We're going to have a fun hearing on food.

COMMISSIONER BASSETT: Food and what else? There was something else that you talked—oh, yes, we talked about tobacco.

CHAIRPERSON JOHNSON: Yeah, two—two fun hearings. Okay. Syphilis. The Fiscal 2018 Preliminary Plan allocates nearly $26 million to SV

control, a slight increase of $849,000 or 3%. When compared to the Fiscal 2017 Adopted Budget, will the department direct this new funding to the prevention of Syphilis, which has increased more than 33% between Fiscal 2015 and Fiscal 2016? Dr. Bassett, I know you're going to say Syphilis is on an increase nationally. It's not just New York City--

COMMISSIONER BASSETT: [interposing] That's correct.

CHAIRPERSON JOHNSON: --but we are better than nationally. I want to know what we can do here in New York City. Even with rising Syphilis rates nationally, what can we do to have a decrease in Syphilis in New York City?

COMMISSIONER BASSETT: Well, I think that one of the things that we've instituted in our Sexual Health Clinics may be part of the—of the answer, but I want to be honest with you that nationally and in our city we don't have a complete understanding of why Syphilis rates are going up. What we are doing now that we hadn't done previously at our Sexual Health Clinics is making available free screens for anybody who wants to get checked. Somewhere I have

among my props that I did bring to show you Our Get Checked. [pause] [laughter].

CHAIRPERSON JOHNSON: What do those emogies mean?

COMMISSIONER BASSETT: [laughs] So they're--they're aimed at people younger than me. They understand them. They—they—so we are doing a--

CHAIRPERSON JOHNSON: [interposing] You know, Dr. Bassett, we've been having conversations about older people needing to have safe sex.

COMMISSIONER BASSETT: Yes, I'm all for older people also having safe sex.

CHAIRPERSON JOHNSON: Okay.

COMMISSIONER BASSETT: What I was talking about emogies. [laughter] The—the—the department now makes available among the other services at the Sexual Health Clinics a—a—no physical exam, clinical encounters screen so that you can be tested for asymptomatic infection, and some people who will test positive Syphilis will have a symptomatic status, and we'll identify them, and then they can—we can determine whether it should be treated or not. So it means that have—are doing much more screening than we have in the past, and this offer of anybody who's 12

or over can come into our Sexual Health Clinics and ask to get checked is proving quite popular. But that said, we also are simply beginning a—an ongoing conversation with the—with advocates and with other clinicians about the problem of rising rates of Syphilis, which has been pretty much limited to men who have sex with men. There has been for the first time a small uptick also in Syphilis in women, which, of course, raises the additional concerns about Syphilis infection during pregnancy. We have something that was initially called the Syphilis Advisory Group. It's now renamed the Sexual Health Advisory Group or SHAG. [laughter] Good.

CHAIRPERSON JOHNSON: You guys are like-

COMMISSIONER BASSETT: [interposing] Some people are still awake.

CHAIRPERSON JOHNSON: What is going on here today, [laughter] Dr. Bassett?

COMMISSIONER BASSETT: And—and the--

CHAIRPERSON JOHNSON: [interposing] It's out of an Austin Powers movie. [laughter]

COMMISSIONER BASSETT: We are working, you know, hard to—to address this issues, but I—I—I

don't think that it's one that will be readdressed. Dr. Daskalakas, if you'd like to add.

DR. DASKALAKAS: I just wanted to put a number behind the—sort of the fact of—of the implementing Express Visits for All. The numbers increased by I just wanted to put a number behind the—sort of the fact of—of the implementing Express Visits for All. The numbers increased by 60%, people who are pursing those visits, and so I think there are lot of data both with people living with HIV and a HIV negative individuals that the most aggressive strategy towards Syphilis other than continuing the work we're doing on promoting condoms and other mechan—barrier protections against transmission is rapid identification and treatment. And so the lower threshold we go the—the better we'll be able to address the situation.

CHAIRPERSON JOHNSON: Yeah, I think one of the confusing things that I hear and you read about when PREP is talked about is the fact that we're a huge supporter of PREP, and we've done a lot to increase access of PREP, but PREP does not do anything to take of Gonorrhea, Clamydia, Syphilis, HPV, any of the other STIs, which we're trying to

bring the uptake rates down. And so I don't know if it's a conflicting message but, you know, condoms is really the only thing that can help you with Syphilis. And so if you are engaging in some type of sexual conduct or a type of a sex where, you know, we want you to use PREP, but you should also know that PREP alone is not going to take care of you for all the other STIs, and that's a hard message to sell.

COMMISSIONER BASSETT: It is and—but we also know that there are some people who don't use condoms, and those are people we see at our sexual health clinics. They come with other sexually transmitted infections and that's why our sexual health clinics are such a good place to have conversations with people about whether PREP is good for them. At the same time, we're continuing to make the case that condoms are the best protection against many STDs, and if you are not sure you can use condoms all the time, you should consider PREP. This is really not too different than the dual protection argument that we make for women who are sexually active and want to make sure that they don't get pregnant, and also want to make sure they don't--

CHAIRPERSON JOHNSON: [interposing] Birth control and condoms.

COMMISSIONER BASSETT: Yes, yes.

CHAIRPERSON JOHNSON: Yes.

COMMISSIONER BASSETT: Exactly. Yes, and Dr. Daskalasas would like to add something.

DR. DASKALAKAS: Some recent data, a modeling study that was presented in March 2017 in Seattle from the CVC actually shows that they do approach PREP not as a drug, but as a program the way that we're doing in New York City. The program itself actually results in increased screening for Bacterial STIs like Gonorrhea, Clamydia and Syphilis, and in the model—in the modeling that level of—of testing, identification and early treatment will over time result in the decrease in both—in all these bacterial STIs. So in effect, encouraging the sexual health of individuals and meeting them where they are from the perspective of strategies for HIV we're going to use, could result in decreases in both Syphilis, Gonorrhea and Clamydia. With that said, 37.5 million condoms will continue to be spread all over New York City reminding people that that is a really great way to prevent STIs.

CHAIRPERSON JOHNSON: So the department provides STI in each of these services at eight full service sexual health clinics that we talked about, two in clean—two in Queens, two in Brooklyn, one clinic in the Bronx and three in Manhattan. However, the department does not maintain a clinic on Staten Island.

COMMISSIONER BASSETT: Correct.

CHAIRPERSON JOHNSON: Should that change?

COMMISSIONER BASSETT: Well, right now we're very pleased to have eight Sexual Health Clinics, and looking forward to reopening Chelsea. You know, the—the-there are—there are services available to people on Staten Island, but it's true that we don't have a Sexual Health Clinic there.

DR. DASKALAKAS: Just to add one—one comment. We actually do have several contracts in Staten Island that focus on—on STI screening in the context of—of pre-exposure for Peroxis (sic), and—and other interventions.

CHAIRPERSON JOHNSON: How many providers on Staten Island?

DR. DASKALAKAS: Unfortunately, in general we don't have a lot of providers on Staten Island at all.

CHAIRPERSON JOHNSON: How many?

DR. DASKALAKAS: So it ends up that there's two dominant CBOs and—and two dominant healthcare systems.

CHAIRPERSON JOHNSON: We should have a physical Department of Health presence on Staten Island.

COMMISSIONER BASSETT: I know that H&H is—has committed to building a clinic there as you have probably learned.

CHAIRPERSON JOHNSON: But shouldn't we have a presence on Staten Island?

COMMISSIONER BASSETT: We do have a presence in Staten Island, but we don't have a Sexual Health Clinic.

CHAIRPERSON JOHNSON: Okay. I'm advocating for Staten Island. Okay, I'm not going to—I mean there is so much more to ask about, but so I'm going to say—I'll a few more questions, but I want to say this. So last year we had a lot of—we had a lot of questions for you all because we didn't

want to keep you here for seven hours, and ask you every question we had. So we said, hey we're going to send you some questions. Give us answers. It took months to get answers. Yes, it did, months and months and months. Months, and months, and months, and months and months so--

COMMISSIONER BASSETT: [interposing] I'll give you my personal undertaking, but it won't take months.

CHAIRPERSON JOHNSON: [interposing] So, I'm going—so we're going to—we're going to—we're going to give you questions, and they need to be—get back to us in like a month or like three weeks, but last time it was like five months, six months, seven months. It was a long time.

COMMISSIONER BASSETT: Well, I very much regret that. I agree that you deserve speedy answers to questions that you have every right to ask us.

CHAIRPERSON JOHNSON: Council Member Koo.

COUNCIL MEMBER KOO: Thank you. Recently I have a few constituents complain to me when they were on the streets they always smell of Marijuana, and so do you--Marijuana. Yeah, they always smell. So there seems to be an increase of people using

Marijuana on the streets. So do you support people using it recreationally?

COMMISSIONER BASSETT: Well, I mean I'm really not sure how to answer that question. I don't consider it particularly a health issues. I know that there has been a move to decriminalize Marijuana and—and I think perhaps you should direct that question to the—your local Police Precinct.

COUNCIL MEMBER KOO: As a—as public health official, can you say—can you tell us the—the—the side effects of smoking Marijuana?

COMMISSIONER BASSETT: Well, there are known side effects with smoking prodigious amounts of Marijuana related to mental health, and—but beyond that I'm really not in the position to—to speak. Certainly smoking tobacco is something that I know a lot about, and I would say that there are a whole ton of information about its health risks. There are some mental health risks associated with Marijuana use.

COUNCIL MEMBER KOO: So would you say smoking Marijuana is safer that smoking tobacco?

COMMISSIONER BASSETT: Well, I walked right into that, didn't I?

COUNCIL MEMBER KOO: Uh-huh. [laughter] Because right now we are encouraging all the kids, yeah, kids to smoke out on the streets and--?

COMMISSIONER BASSETT: I'm not sure how to answer that question. It is certainly not safe to smoke tobacco. How if I put it like that?

COUNCIL MEMBER KOO: Another thing I want to bring up about tobacco use is like the city always said the smoking population is not increasing, right because of the high tax.

COMMISSIONER BASSETT: Well, we had a—a—as Chairman Johnson referred to, we've had 5 point approach to tobacco control that included legislation, taxation, public education, support for cessation, helping people quit and evaluation. This has been very successful over the last 15 years and driving down tobacco use rates. In adults it's going down from over 205. Well, we had a—a—as Chairman Johnson referred to, we've had 5 point approach to tobacco control that included legislation, taxation, public education, support for cessation, helping people quit and evaluation. This has been very successful over the last 15 years and driving down tobacco use rates. In adults it's going down from

over 20% to now about 14%, but we want it to go lower. Our goal is to get it down to—to 12% by 2020.

COUNCIL MEMBER KOO: But from my observation, I—I see a lot of immigrants they—they smoke especially in my district.

COMMISSIONER BASSETT: Maybe the men.

COUNCIL MEMBER KOO: No, because—you know, why because it's the tax because you don't know they always find cigarettes either in—in Long Island, New Jersey.

COMMISSIONER BASSETT: I see.

COUNCIL MEMBER KOO: But all—some untaxed cigarettes from the Indian reservations, and--

COMMISSIONER BASSETT: Yes.

COUNCIL MEMBER KOO: -and it's easy to buy those untaxed cigarettes, and you can buy in the coffee store or bodegas, you know.

COMMISSIONER BASSETT: Well, I can tell you that it's illegal--

COUNCIL MEMBER KOO: [interposing] Yes.

COMMISSIONER BASSETT: --to have unstamped cigarettes and to sell them in New York City, and people who are doing that are taking the chance. The sheriff can look for these and if they

are unstamped, they—they face consequences. So the issue of untaxed cigarettes of tax avoidance to cigarettes has been raised ever since there's been a protracted effort to raise the price of cigarettes, and tax avoidance has been an issue but we know that unbalanced cigarettes still become more expensive with—with the raised tax and taxation of cigarettes remains a proven method to reduce tobacco use in the population. There is variability in who smokes in our city, and we have a lot of data on this. We'd be happy to talk with you about it, and I would encourage you to point out to the small business owners that you interact with that they are taking a chance when they sell cigarettes that are untaxed because it's not legal to do that.

COUNCIL MEMBER KOO: No, but it's easy to buy untaxed cigarettes. They don't have to buy them in stores, too. There's the—the underground market where you can call and they—they deliver it to you on the streets.

COMMISSIONER BASSETT: It's still illegal.

COUNCIL MEMBER KOO: Yeah, yeah, but—but so my—my point is the high tax doesn't help the

people in New York City because we are so close to other places. You know, we can buy Great Neck. You can buy in New Jersey just as cheap, or you can buy in the underground, which is like $7 cheaper per pack. So remember you see all the smoking has been done. Actually, it's not done, and a lot of people still are smoking.

COMMISSIONER BASSETT: No, we have very good data showing that the number of people who smoke the proportion of New Yorkers who report that they smoke has gone down. Additionally, we have sort of hard evidence from the biological surveys that we've done where we test of metabolites of Nicotine and we know that the rates of Nicotine are going down in our population including among people who don't smoke because, of course, second hand smoke is a real risk factor as well as being a smoker yourself, being around smokers. So the amount of evidence of Nicotine in—in people who are not smokers has also gone down over time. So I appreciate your observation because the numbers of places that people can smoke has become progressively more limited that you're seeing people smoking in places where they're allowed to smoke, but we have very good data showing

that smoking rates have gone down. We want them to go down further. They haven't gone down far enough, and I would be happy to share data with you on the importance of price as a tool to drive down tobacco use.

COUNCIL MEMBER KOO: The reason why I think this outreach because I have grandmother complain to me right on the streets. They say oh, my grandson even though he's only 16, 15 they can buy cigarettes off the street.

COMMISSIONER BASSETT: But that's against the law, and that's why you have to report the--

COUNCIL MEMBER KOO: [interposing] Yeah, and if they go in the store they check their ID, but when you call a certain number they can get it or they can buy it at like a place. A lot of places they can buy untaxed cigarettes.

COMMISSIONER BASSETT: We should work with you, Council Member and try and identify those hot sports for sales that you have—have encountered. The law in New York is that you have to be 21 or older to buy a pack of cigarettes, and the law in New York City is that you have to buy taxed cigarettes that have tax stamp on them. So, you know, we all

know that the enforcement of laws is not perfect, but it is not absent, and we know that the Department of Cultural Affairs does do spot checks to see whether cigarettes are being sold to under aged individuals, and there are real consequences if you violate these laws. So we'd be happy to try and find out from you where you're finding such profligate ignoring of your—of the law.

COUNCIL MEMBER KOO: Okay. Thank you.

CHAIRPERSON JOHNSON: Thank you, Council Member Koo. Okay, we're doing to rifle through these very, very quickly. The Fiscal 2017 Preliminary Capital Budget Plan includes $2 million Fiscal 2017 and $8 million in [coughs] Fiscal 2018 to construct full service animal shelters in the Queens—in Queens and in the Bronx. The plan also includes $3 million in Fiscal 2017 to upgrade animal shelters in Brooklyn, Manhattan and Staten Island, and to invest in various animal welfare projects. What is the status of these projects? Have you identified the sites? When will we get full service animal shelters? I feel like it's like Groundhog Day again on this.

COMMISSIONER BASSETT: I—I'm afraid on this you will get to say that again because we are continuing to seek sites in the Bronx and in—in Queens we're getting all the support from the people that we should be getting support from. We visited over 40 sites both city-owned and privately owned sites in Queens and the Bronx, and I am very hopeful that very soon I'll be able to tell you about these sites, but we do not have any thing to share with you today. What I can reiterate, and I appreciate that I reiterated this last year is that this Administration remains committed to five full-service animal shelters, one in each borough. I—I can tell you that we're expecting Staten Island to open up soon the late summer or early fall.

CHAIRPERSON JOHNSON: Is $10 million sufficient to complete these projects?

COMMISSIONER BASSETT: We are confident that we will get all the funding that is needed for these projects.

CHAIRPERSON JOHNSON: But $10 million is not sufficient?

COMMISSIONER BASSETT: I doubt it.

CHAIRPERSON JOHNSON: So why didn't the Administration include more funding in the Ten-Year Capital Strategy?

COMMISSIONER BASSETT: [background comments] The $10 million for site acquisition not for-not for design and construction

CHAIRPERSON JOHNSON: But I don't that--

COMMISSIONER BASSETT: [interposing] The site acquisition and design. I'm correcting.

CHAIRPERSON JOHNSON: But I don't think $10 million is even enough for site acquisition.

COMMISSIONER BASSETT: Well, we may be lucky and find city-owned property, which helps.

CHAIRPERSON JOHNSON: So when will we get an update on this?

COMMISSIONER BASSETT: As soon as I can tell you. You know, I really want to be able to give you an update on this.

CHAIRPERSON JOHNSON: So, in December [background comments].

COMMISSIONER BASSETT: I had forgotten that. Sorry. They said—I'm—I'm being told that the Council recommended that we put $10 million in the budget for site acquisition and--

CHAIRPERSON JOHNSON: That we--?

COMMISSIONER BASSETT: [interposing] I don't want to—that I don't want to go through. We are committed to five full-service shelters, one in each borough, and you and we have been working on identifying sites.

CHAIRPERSON JOHNSON: Okay.

COMMISSIONER BASSETT: As you know, this was a loss--

CHAIRPERSON JOHNSON: [interposing] I—I understand. I just want to be clear because I don't want-I don't want things to get twisted in any way. We had a hearing on this, and we recommended that the Administration come up with all of the money for two shelters.

COMMISSIONER BASSETT: That's my recollection.

CHAIRPERSON JOHNSON: Yes, and then as part of our official response in our budget response documents, which we have give every year, the Council includes all sorts of numbers, and last year the number we put in was $10 million because there were 100 other competing priorities, but the position that I've had and that I think Speaker has had for three

years has been whatever the amount is. So I don't want anyone to hang their hat on the fact that $10 million showed up in one budget response offering.

COMMISSIONER BASSETT: Yeah and I agree with you. This isn't worth talking about.

CHAIRPERSON JOHNSON: Okay.

COMMISSIONER BASSETT: We are committed to identifying a site, acquiring a site, designing the shelters, building the shelters, and opening the shelters so that every borough in this city will have a full-service shelter.

CHAIRPERSON JOHNSON: So in December the department reported that a rare strain of bird flu had infected dozens if not hundreds of cats--

COMMISSIONER BASSETT: Yes.

CHAIRPERSON JOHNSON: --at the Manhattan Animal Shelter on East 110th Street. So you've been to that shelter, right? Have you been that shelter?

COMMISSIONER BASSETT: I have not, not in recent years.

CHAIRPERSON JOHNSON: Okay. So I haven't been Brooklyn--

COMMISSIONER BASSETT: [interposing] But we don't think it had anything to do with shelter conditions. This is novel virus.

CHAIRPERSON JOHNSON: [interposing] Well, walk through that shelter.

COMMISSIONER BASSETT: That this was a novel virus in cats. I'm actually very proud of the veterinary staff--

CHAIRPERSON JOHNSON: Me, too.

COMMISSIONER BASSETT: --and the animal care and control that they—it was rapidly identified as they brought in external expertise that they worked collaboratively with the ASPCA--

CHAIRPERSON JOHNSON: [interposing] Yes.

COMMISSIONER BASSETT: -and others to move the cats into quarantine. There were 500 cats.

CHAIRPERSON JOHNSON: [interposing] The Times did a great piece--

COMMISSIONER BASSETT: [interposing] Yes.

CHAIRPERSON JOHNSON: --on showing the clinic they set up, and it was—they did a remarkable job. The reason why I bring it up even if it was novel for whatever reason, the shelter conditions of the existing shelters are really bad. We walked

through. They're really bad conditions. I adopted my cat from that shelter. I mean they're not—they're not good sites, and one of the issues that AC&C brings up is the fact that they don't have quarantine areas that are big enough when animals get sick. So when a virus is spread throughout the shelter, and it's harder to contain it just because the physical plant and layout of the shelter doesn't lend itself to being able to take care of these issues in the way they need to given the shelter population size. I say all that because there are a few things that I think would work. One is getting the renovations done at the existing shelter on the garage next door to build an adoption center for healthy animals, and having more space for quarantine in the existing shelter. Number two, which I think is really, really important is the fact that the—the city's contract with AC&C it's a five-year contract, a $5 1.9 million contract with your department. The contract requires AC&C, as you said, the request to recuse all homeless and abandoned animals regardless of their physical condition and to provide shelter and care to seize animals. There's not enough money. They need more. They've been doing all sorts of amazing programs on

Surrender Prevention Programs, Socialization Programs to get the animals more easily adopted. They're doing really cutting edge fantastic great stuff. I am really proud of the work that they're doing. I think they made a huge turnaround to getting the no kill number up. They need more money. They don't need tons more money, but they need more money, and so throughout this budget cycle, I am going to push for your department to get money from OMB to increase their amount a little bit to get them the stuff they need so they can continue to be successful.

COMMISSIONER BASSETT: Well, I'm really happy to hear you speak this way about AC&C. We're very proud of the work that they've done. We're proud of the work that they did in identifying and responding in to the cat flu outbreak, and I'm proud of the work that they're doing generally. They're— they're doing a great job. I absolutely agree with that assessment.

CHAIRPERSON JOHNSON: And I do not blame you--

COMMISSIONER BASSETT: [interposing] And we do have--

CHAIRPERSON JOHNSON: --I don't blame the deer death on AC&C.

COMMISSIONER BASSETT: Oh, good. Yes, I know this was the one I knew it's history.

CHAIRPERSON JOHNSON: [interposing] You could talk about deer and turkeys and pigs on Staten Island and--

COMMISSIONER BASSETT: Yes, and there's not really much to update you on all this--

CHAIRPERSON JOHNSON: Okay, so I--

COMMISSIONER BASSETT: [interposing] Send them along and we'll do our best to--

CHAIRPERSON JOHNSON: Maybe that's how we should end things today.

COMMISSIONER BASSETT: With Wilbur?

CHAIRPERSON JOHNSON: Well, I think pigs should be legal in New York City. You don't?

COMMISSIONER BASSETT: Oh, no, I don't.

CHAIRPERSON JOHNSON: No. Okay.

COMMISSIONER BASSETT: I'm happy to discuss it as ever.

CHAIRPERSON JOHNSON: It's not the most important thing [laughs]. So, we have a bunch of questions on Take Care New York 2020, the World Trade

Center Health Program, Public Health Local Assistance, the Centers for Health Equity, which we talked about, chronic diseases, Cure Violence, Hepatitis, Ending the Epidemic, Homeless Shelter Pest Control, Emergency Preparedness, Regional and Cooling Tower Inspections and how successful that's been. The Neighborhood Action Health Centers, which you talked about, bioswales, cheering you on the birth certificate and the great job you all have done on that. Emergency response in the face of storms, NYU Langone Medical Center and what they had to do in the aftermath of Sandy, pesticides, medical marijuana, NYCHA, the Pet Store Decision, which the city won on, Vaccination Rates, which Council Member Kallos talked about, and Weight Stations and Sanitation and how that impacts public health in New York City. So we could spend the next seven hours talking about those things if you wanted to.

COMMISSIONER BASSETT: We have a very extensive portfolio I'm told.

CHAIRPERSON JOHNSON: But we have to not make the Health and Hospitals Corporation wait much longer. I—I do want to say that on this entire list, which it's a long list I am really, really, really

proud that almost three years ago when I first came into this position, and when you first became Health Commissioner, one of the first things we worked on together was changing the gender marker process for transgender New Yorkers, and your team spent an enormous amount of time on that as did we at the Council and the Mayor's Office and to see that over 700 New Yorkers have been able to take advantage of that and have an accurate birth certificate and each story behind that hearing from—I've been hearing from New Yorkers who don't live in New York any more, but were born here and so they're able to come back and get an amended birth certificate because this was their place of birth. And what that's meant to them as it relates to government identification and changing crucial documents that are important to them. What we are seeing at the federal level with the federal government of the entering (sic) protections for transgender students that the Obama Administration put into place, and the continued epidemic of violence against transgender of color. In New York City homicides and brutal beatings, hate crimes that take place even in New York City. The fact that we were able to do this as one of the first

things in the first year of this Administration and the first year of this Council, and to now see the dividends that are being paid, and the human lives that are impacted I think that's a good way to end this hearing because I'm really proud of that work that we did together.

COMMISSIONER BASSETT: It's been a pleasure working with you and thank you. I agree.

CHAIRPERSON JOHNSON: So we have a lot questions. We're going to get them to you, and we're going to have the tobacco hearing, which I think we're going to agree a lot on, and we're going to have the food service hearing, which we're not going to agree a lot on, but I look forward to working together.

COMMISSIONER BASSETT: Thank you very much, and thank you for all your work.

CHAIRPERSON JOHNSON: [interposing] Thank you. Thank you, Commissioner Bassett. We're going to adjourn for five minutes. [gavel]

COMMISSIONER BASSETT: Thank you. [pause] [background comments]

CHAIRPERSON JOHNSON: [gavel] Good afternoon. I'm Council Member Corey Johnson Chair of

the City Council's Committee on Health. During today's hearing we will review the New York City Health and Hospitals Fiscal 2017 Adopted Budget and the Fiscal 2018 Expense highlights. H&H did not provide a Fiscal 2018 Preliminary Plan so our hearing report was limited in scope. However, I look forward to addressing H&H's current cash based operating revenues and expenses this afternoon. I will also review key indicators in the Preliminary Mayor's Management Report for Fiscal 2017 including metrics for hospital utilization, patient satisfaction and Metro Plus. I'd like to first address the current political landscape and the recent defeat of the American Healthcare Act. As you know, the repeal of the Affordable Care Act would have resulted in substantial financial losses to New York City and New York State including the loss of hundreds of millions of dollars in federal subsidies to H&H. Regarding the H&H patient population, approximately 200,000 insured patients and approximately 425,000 uninsured patients would have been severely adversely affected. The Affordable Care Act remains the law of the land, thank God, but the State and federal governments may still enact changes to Medicaid, Medicare and other

healthcare programs that would affect H&H's efforts to balance revenues and expenses. Significantly, the $1.1 billion revenue generation strategy and H&H's transformation plan relies heavily on state and federal funding. In terms of anticipated budget reductions, a provision in the Affordable Care Act cuts DSRIP payments or DSH payments, Disproportionate Share Hospital Payments to states on October 1, 2017, which is about six months away. These projected declines in safety net funding coupled with the decrease in hospital utilization and an increase in uncompensated care have hampered H&H's efforts to achieve financial stability. To this end, I would like to discuss the Commission on Healthcare for our neighborhoods' recent findings and recommendations on H&H's transformation strategy. The City tasked the commission with addressing four primary goals for the city's City Hospital System success:

(1) stabilizing funding;

(2) expanding community-based healthcare;

(3) improving efficiency; and

(4) remodeling an outdate system.

However, the Commission's report does include the kind of bold strategies necessary transform our beleaguered—beleaguered hospital system. The vital role H&H plays in the lives of New York City's most vulnerable citizens, and in the city's greater healthcare ecosystem is not lost on me or this Council. H&H provides nearly half of all uninsured hospital stays and emergency room visits in New York City as well as 80% of uninsured non-emergency hospital visits. In the current political climate H&H's care for the uninsured proves essential, but it is precisely because of its importance to the city's public health and human welfare that we must transform H&H, a fee that will require a robust cost savings program, an aggressive restricting strategy and substantial political will. I look forward to addressing these issues with you today, as well as topics pertaining to Correctional health services the One City Health PPS and the Caring Neighborhoods Initiatives among others. Before I turn it over to the interim president of H&H and CEO Stanley Brezenoff, I want to say that as I already said in these remarks, but I think it's important to reiterate our public hospital system is

the best hospital in the United States of America. When the President of the United States comes to New York, the designated place to bring them if something happens is Bellevue. That is because we have a world class hospital system. So if you are hospital that is tasked with taking care of the President of the United States or you are the hospital system that is taking care of hundreds of thousands of undocumented immigrants in New York City and everyone in between, their health, wellbeing, financial stability and future of that system is really something that all New Yorkers should care about and rely upon as we move forward.

Scary times that we're in and I'm sure Stan you're going to talk about it in your testimony, but just because we were able to have a big win a week ago and staving off what was going to be a disaster for New Yorkers and Americans generally, there are still really bad cuts that on the table from the federal government as it pertains to reimbursement rates, as it pertains to public hospital funding, safety and hospital funding. All the things we care about, and even if this Administration didn't come to power and appoint these

zealots and idea logs to be running government in Washington. Even if we had an administration that was more sympathetic, and that shared our values we were still going to be in a difficult spot. And so with this Administration, and with key decision makers in Congress and out federal agencies now making what I consider to be immoral, inhumane decisions as how it's going to affect Americans, we have to have a better plan now more than ever the importance of it. And I know these decisions aren't easy, and I know that hospital closures aren't on the table, and I know that severe layoffs aren't on the table. And I'm not saying they should be, but when you take those things off the table, it becomes a lot more difficult to actually stabilize the system, and I look forward to talk about that today, and figuring out a strategy on how the city can actually ensure the financial long-term health and wellbeing of this public benefit corporation while at the same time sometimes making painful, difficult decisions that are necessary for the long-term health. So with that, I want to turn it over to the Interim President and CEO of New York City Health and Hospitals Mr. Stanley Brezenoff. I don't know why you took this

job, [laughter] but I look forward to hearing from you.

STANLEY BREZENOFF: [laughs] They made me an offer I couldn't refuse. Thank you, Chairman Johnson and—and members of the—the Health Committee. I've already been introduced. With me at the—at the table is our Chief Financial Officer PV Anantharam. At the far end here is the Chief Medical Officer of H&H of Health and Hospitals, Michelle Allen and John Jurenko our Vice President for Government and Community Relations. Before I begin my testimony, I—I'd just like to do a quick response to the—the apt description that—the—the-the Chair made about events in Washington and the overall threat. We—we certainly dodged a bullet, but as you know, the gun is still loaded, and we were all ready in a very fragile situation, but I want to note that it was the combined efforts, the political will, the work with allies and advocates as exemplified by the leadership in the Council that the—the chairman himself embraces the New York Congressional Delegation and so on that made this—this victory possible, and I believe future success possible as no doubt we will have to combat additional threats emanating from Washington and—and

elsewhere. I'd also like to acknowledge the members of the Commission on Healthcare, which you also refer to for our neighborhoods for their recently released recommendations, which will help to inform Health and Hospitals comprehensive plan to transform into a high performing competitive and sustainable community based system, our need to transform is predicated on two imperatives that were alluded to earlier: The need to better serve our patients and communities by enhancing access to ambulatory care, addressing social determinants of health, and right sizing our clinical services to provide 21st Century Healthcare for all New Yorkers regardless of their ability to pay and regardless of their immigration status.

A major financial challenge brought on by higher costs to run our system and reimbursement policy changes that has yielded a shortfall associated with being the city's single largest provide of care for Medicaid and uninsured patients. The need is intensified by the budget and policy uncertainty I'll call it now emanating from Washington. But more than ever, we are committed to caring from all New Yorkers as effectively and efficiently as possible. When we testified before

the Council last year, we were working to close our FY17 gap through a series of transformation initiatives that sought to improve our budget by $779 million. We expect to be successful in closing that gap by June 30th. We're on track to achieve $661 million in increased revenue and $118 million from savings. Specifically, we've done this growing our Medicaid revenue by participating in the New York State Care Restructuring Enhancement pilots, Crack and Value-Based Payments Quality Improvement Program. DVPQHP. That's one thing that's changed since I've been there. There are even more acronyms and the—and the abbreviations, but $390 million. Increasing revenue from MetroPlus, $102 million earning additional DSRIP, Delivery Service Reform Incentive Payments for $45 million; increasing the upper payment limiting funding for $45 million; improving revenue collection through revenue cycle management, $55 million; and increasing reimbursement earned through FQHC status of our diagnostic and treatment center $25 million. On the saving side, we've reduced costs by leveraging economies of scale and purchasing, $63 million, and reduce the use of overtime, temporary staff and closely monitored our

headcount to achieve savings through attrition of $55 million. This will allow us to end the Fiscal Year on target with a cash balance of approximately $100 million and meet our obligations with—with the City.

CHAIRPERSON JOHNSON: That's a big deal.

STANLEY BREZENOFF: Thank you and I--

CHAIRPERSON JOHNSON: [interposing] I don't want to interrupt. I want you to keep going but it's—it's remarkable actually.

STANLEY BREZENOFF: It is very remarkable and attributable to the efforts of a great of people. I failed to note that there are leaders of Health and Hospitals seated here to—to make sure their Interim President doesn't stray too far off the mark, and they're—they're here and, of course, my colleagues around the table, and--

CHAIRPERSON JOHNSON: [interposing] I'm giving all the credit to PV.

STANLEY BREZENOFF: And I—[laughs]

CHAIRPERSON JOHNSON: Okay, you just call him.

STANLEY BREZENOFF: This is slight of hand here.

CHAIRPERSON JOHNSON: Sorry.

STANLEY BREZENOFF: [laughs] So, a lot of credit to go around and I—I—I would note that much of this work has its roots in the leadership of—of my predecessor. So, the Revenue Enhancing Initiative highlights deserve some special attention, and that the growing of value based payment arrangements where we expect it to receive $390 million through CREP and the DVP, which is a five-year initiative in which the system partners with One City Health and managed care plans to incentive and support the transformation through value based payment arrangements. The future of the—of healthcare.

Increased Metro Plus Revenue. Metro Plus is expected to deliver more than $102 million and additional revenue by the end of this Fiscal Year. It has met its revenue targets so far through risk management of its population achieving high quality scores that resulted in bonus funds a very, very nice achievement and significant membership growth in the essential health plan line of business. The Health and Hospitals will receive the $45 in DSRIP funding to promote the very important goal of community collaboration and system reform with a goal of reducing avoidable hospital use by 25% over five

years, and in the case of upper payment limit, the State is converting, of course, certain amount of funding to support the DSRIP program funding objectives. As a result, Health and Hospitals expects to receive $45 million in—in payments.

The revenue collection from insurance companies and Medicaid here we're on track to meet a target of $55 million in additional revenues. This is associated with a focused effort to ensure that we're dealing with the care provided to ensure patients and not leaving money on the table. This work on revenue cycle management is a critical element in becoming more operationally efficient in an increasingly complex billing environment. These focused efforts are needed to ensure that that Health and Hospitals is getting all of the funds it is entitled to receive from health plans and the Medicaid program that it provides to insured patients.

Obviously, garnering additional reimbursement through FQHC status something we've talked about before after several years of working with federal officials on obtaining the approval of that status for our DNT treatment centers, Health and

Hospitals has earned extra reimbursement for services provided at Gotham Health and related satellite sites. We're expecting to achieve $25 million in extra revenue this—for this effort.

On the cost reduction side, using the Economies of Scale we're a very, very big purchaser. We're on track to achieve savings reductions in spending by nearly $63 million in FY17. This major push of savings is achieved through contract negotiations with suppliers, and vendors as well efforts to improve our management of the supply chain. It's another essential part of our work to enhance our operating facility—efficiency.

Reducing Overtime and use of temporary staff, managing headcount and finding other personnel cost efficiencies. Health and Hospitals is staffed by a dedicated workforce, and we need to strengthen it and make it more efficient. Personnel costs are 70% of our overall costs, and we closely monitor our headcount. We have had substantial success in this regard for this year through an attrition based workforce reduction strategy. At the same time we have been scrutinizing the use of overtime and agency staffing to actually reduce our workforce on a global

basis. Our efforts have put us on track to achieve $55 million in renewable savings in personnel costs looking to the future. While this is positive news on our budget, we're not complacent. It will take constant vigilance to achieve increased revenue and savings, which are more important now given the significant threats described earlier by our Chairman to federal funding. Last Friday se avoided that catastrophe with the pulling of the Affordable Healthcare Act with the replacement to the ACA from a vote by the House of Representatives. While this is a short-term victory, a wonderful victory earned the hard way, we know that budgetary, regulatory, legislative and other administrative actions will continue to pose threats to the ACA. As a reminder, if the ACA were fully repealed, New York State estimated that 2.6 million New Yorkers would lose health insurance coverage including up to 1.6 million residents of New York City. Based on this estimate, more than 200,000 Health and Hospitals patients would be at risk of losing coverage. Moving forward we will continue working in partnership with the Mayor's Office, members of New York City's Congressional Delegation, the members of the City Council, our

colleagues in hospitals nationwide and union partners, community based organizations, healthcare advocates and our hospital association partner against further potentially damaging actions.

As we look to FY18, I'm encouraged that all the groundwork that we have laid in FY17 has provided us with a running start that will produce real savings next year. A great deal still remains to be done, and we're redoubling our efforts to improving our revenue cycle, our supply chain and through operational efficiencies. We will be ready to provide more details on these efforts at the upcoming FY18 Executive Budget Hearing. While we're focused on these efforts, it is important to note that a portion of the Fiscal Year gap in—in FY18 is a result of the first year of the federal disproportionate share hospital funding cuts scheduled to occur later this—this year. [pause]

Moving to transformation, Health and Hospitals is focused, is about clinical and operational approach to proactively keep patients healthy and conveniently serve them in the communities where they live and work. Transforming from sick care to healthcare means ensuring access to

routine primary and preventive care. Health and Hospitals is—is expanding this care as well a providing better care management, population health approaches, and linking patients up to social services to more effectively meet their needs and help address social determinants of health. Primary and preventive healthcare helps our patients manage their chronic conditions like diabetes and high blood pressure so they don't suffer avoidable complications. We have continued to sustain improvements in appoint of—appointment availability for primary and preventive care. Since January 2015, there has been a 65% increase in our wait time for new adult primary care patients from 55 days in 2015 to 19 days in 2017. Likewise for new pediatric patients there's been a significant decrease in wait time, 57% for this time frame. Health and Hospitals is in great—integrating behavioral health and primary care to provide more holistic care to our—our patients. We serve the vast majority of behavioral health patients in New York City. We're doing this by increasing access to depressing screening and maternal health and other at-risk populations and providing increased mental health support for victims

of domestic violence in Family Justice Centers. We recently launched at Health and Hospitals a digital campaign to encourage women to access our high quality affordable and culturally responsive medical family planning and mental health services. We're also reassuring them that we will maintain access to all across all five boroughs regardless of immigration status or ability to pay. We're greatly concerned that the threats to these prevent giving them primary care services, but I want to assure the Council that Health and Hospitals is committed to protecting these safety net services and do what— whatever is necessary to ensure that access is available for our patients and all New Yorkers who need them. Recently, the Mayor announced Healing New York City, a comprehensive effort to reduce opioid overdose deaths by 35% over the next five years. Health and Hospitals is the key partners in this initiative reinforcing our commitment in this area to develop a system of excellence. We will assist an additional 20,000 New Yorkers to gain access to medication assisted treatment by 2022 through the transformation of our substance use chair models. We'll do this through several modalities with a focus

on addiction prevention. We will seek to be leader in reducing over prescription by training physicians about aim management without prescription opioids and/or with less frequent prescription opioids. With a focus on overdose prevention, we will maintain— maintain routine Naloxone dispensing in and across clinical settings. With a focus on highly effective treatment we will more than triple the number of providers from 100 to 450 certified to prescribe Buprenorphine for the treatment of opioid addictions. We will increase the number of patients serviced in our Methadone clinics, and we will launch addition medicine consult teams at four of our facilities. We are also pleased to announce that we've made enormous strides through enhanced behavioral health services. I would note particularly that at Kings County we're gratified that the U.S. Department of Justice has acknowledge these necessary improvements and ended oversight of our program marking a successful transformation to our high quality patient centered psychiatric program that's dramatically improving the experience of the 11—11,000 New Yorkers it serves every year. An essential component of our transformation work is improving clinical quality,

the Leapfrog Group the only independent rating program that focuses solely on how effectively hospitals keep their patients safe. Recently awarded the grades of A or B to only five hospitals in New York City for patient safety. Notably, all five hospitals are part of Health and Hospitals. The Leapfrog Hospital Safety Grade uses 30 measures of publicly available hospital safety data to grade more than 2,000 U.S. hospitals twice per year. These grades are calculated by top patient safety experts, peer reviewed, fully transparent and free for the public to see. We recently announced work also on an initiative to centralize laboratory services with Northwell Health. This is a joint venture to provide a state of the art shared centralized laboratory to be built in Queens. This initiative will enhance quality in patient service while reducing costs for both health systems and their hospitals. The 36,000 square foot two-story lab will primarily perform microbiology tests including molecular diagnostics from local hospitals, clinics, physicians' offices incorporating the latest technology and advanced robotic testing assistance. Information technology is fundamental. It's a foundation for our

transformation and upgrading our information technology infrastructure to support an integrated patient focused approach for care delivery and more efficient operations is critical for transformation. Last April Health and Hospitals began installing Epic, the industry leader for advanced electronic medical records systems. This new system not only helps our clinicians to provide safe, high quality and efficient care, but also facilitates patient secure online access to their medical records and convenient online service such as prescription refill requests and contacting their providers with questions. Epic is now being used at Queens, Elmhurst and Coney Island Hospitals, and has already helped to improve the quality of care at these hospitals. Since Epic was installed at Queens and Elmhurst, both hospitals were independently assessed by the Leapfrog Group, and it received the high standards of safety and quality rating in catching potential harmful preventable errors related to medication administration. Since online prescription refills have been available, there has been approximately a 24% request—reduction in request at these hospitals for in-patient appointments solely to

refill medications, which freeze up both the patients and our providers who can treat more patients. Another important project paving the way for integrated clinical care across our system and enhancing operational efficiency is a radiology integration program that will enable electronic sharing of images among system facilities and improve imaging work fall—workflow at individual care centers. This will enhance efficiencies by bringing the off-hour reading of images previously performed by outside radiologists in house. This program is projected to save approximately $3 million a year when fully implemented at the end of the year. Finally, implementing an enterprise resource planning system is an executive—a central management tool that will improve the integration and efficiency of back office operations such as supply chain, finance, payroll, human service functions when full implemented. The system will be rolled out in phases through 2019, and will integrate many back office functions into one single IT application to help reduce redundant tasks, save time and money, and support our high reliability health system. I want to say a word about the correctional health, and note

that Dr. Patsy Yang, who's here to amplify and answer any questions that you might have, but I want to note that we've made tremendous progress over the last year to improve the care that's provided in our city jails. Correctional Health Service has continued expanding its workforce, enhancing operational efficiencies, expanding successful programs and services and leveraging other Health and Hospitals programs and services to improving the care and during and after incarceration. They have recruited highly qualified mission driven health professions as well as strengthen support for frontline clinicians. They have a unified mental health service with clinical supervisors in every mental observation housing, and a clinical education officer to support improvements in clinical practice. They generally improve deficiencies with EMS transport and improved— and improved access to care and a pilot with the Fire Department, Bellevue, Elmhurst and the Department of Corrections. Correctional Health Services are also now a part of the Health and Hospitals Supply Chain System giving a broader access to medical surgical supplies, and—and equipment. There's a lot more to say about the Correctional Health, but I'll—I'll

leave that to later with—with Patsy. We're—we're really proud of what's been accomplished, and the transition from Corizon.

On capital, I'd like to briefly highlight some key capital projects that have received Council support. In Queens work is underway at Elmhurst Hospital to renovate and expand its adult emergency room. The project is currently in a design phase, and we expect that it will be completed in 2019. I want to thank the Queens Borough President and the Queens City Council Delegation for their—for their support. I know they're going to be proud of the—the product. On Staten Island the Vanderbilt Avenue site will open this fall. The new $28 million 18,000 square foot ambulatory care facility will offer comprehensive primary medical and mental health services for both children and adults. This site will also feature an after hours urgent care center to better accommodate patient needs, and I want to thank Council Member Debbie Rose for her contribution to this project. Metropolitan's LGBTQ Family Health Center design phase was completed in February. The solicitation phase has been completed, and the project completion is estimated about January 2018,

and I want to thank the Speaker for contributing the funding to make this project possible. I want to thank Council Member Eugene for his commitment to provide funding for Kings County Hospital to replace an upgraded needed medical equipment. The renovation expansion and outfitting of the Roberto Clemente Clinic will be completed by May 2017. Patients will now have access to behavioral health programs. We would like to thank Council Member Rosie Mendez for her unwavering support and contribution to the successful completion of this project. We're also becoming more energy efficient through a dozen projects at our facilities. We've upgraded boilers that are more efficient and use cleaner fuel oil. Through decreased usage and cost reductions we've achieved $21 million in savings for our system. Our efforts have had the added benefit of reducing greenhouse gas emissions by 21% and we're on track to meet our goal of reducing greenhouse gases by 50% by 2025. Additionally, we've installed new windows and lighting systems in many of our facilities. As a result of our efforts over the last fiscal year, we've seen a decrease in energy use of more than 10% system—system wide. It's worth noting that on FEMA

projects in addition to the aforementioned ongoing capital projects we continue to work on key projects to rectify the damage caused by Hurricane Sandy and to make our facilities more resilient to protect them in the future. We've been working closely with our partners in the Mayor's Office of Recovery and Resiliency and the New York City Economic Development Corporation on these initiatives and project to relocated and protect the critical infrastructure equipment including electrical and mechanical, heating and ventilation units as well as projects to mitigate the effects of floods are underway at Bellevue, Coler, Coney Island and Metropolitan.

A big part of all of our initiatives is the effort to—to grow, and insurance in enrollment outreach is a part of that, and we're working closely with the Mayor's Initiative Get Covered New York City to encourage and assist New Yorkers in signing up for healthcare. Get Covered New York City, which has also had the strong advocacy of our committee, committee chair is an ambitious partnership between the Mayor's Office, our health system and other city agencies to proactively engage uninsured New Yorkers who have previously—previously visited one of our

patient care sites. I was present at the press conference where this was—sort of gave birth, and both the Chair and the Mayor made note that it was in effect—in effect the first challenge to the attack on the ACA by saying in the face of that still forming attack, but much anticipated really the dread both the Chair and the Mayor said, No, we defy this. We're going to enroll, and I do remember what you said that—that day, and it's carried through as a way to deal with what's going on in Washington generally. To maximize our effectiveness in this growth work we're revamping our internal eligibility screening and enrollment procedures so that all uninsured payment—patients who come to Health and Hospitals for needed healthcare or for enrollment assistance can be effectively screened for health insurance and work with personnel who can help them submit applications for cover—coverage. We enroll thousands of people every month in addition to the thousands of our patients enrolled on site at our facilities by our partners at Metro Plus and Health—Health First. Making sure that we will take every opportunity to enroll our patients who are eligible for insurance is really critical to protecting their health and the

continuity of care that they need. And the need for this work is going to grow regardless of what they try to do in Washington, and we should continue to actively enroll even as they try to cut back on—on programs. We continue to participate in Action Health New York City, and initiative--initiative led by the Department of Health and Mental Hygiene. This program provides care management services for approximately 1,300 low-income New Yorkers ineligible for public—public coverage.

Before I conclude, I want to mention what we're doing to expand our community outreach and involvement. I suppose that that is most important even more important than it routinely is in times of great uncertainty and—and threat. And so last fall, we began a series of meetings in all five boroughs and across diverse communities of New York City to help educate more than 300 New Yorkers about changes to the city's healthcare landscape, and to learn from them about their own community health needs and priorities. We partnered with the New York Immigration Coalition and Community Resource Exchange on these forums, and we just posted the report on our

website that outlines the key themes and findings from these conversations.

Lastly, I want to reiterate our commitment to our patients, to our communities during these unsettling times. Like you, we're working to serve and protect all New Yorkers. As a safety net provider, New York City Health and Hospitals remains staunchly committed to caring for individuals and families regardless of their immigration status or ability to pay. In December, I issued with Commissioner Ederwall (sp?) an open letter to immigrant New Yorkers to reassure all immigrants that they can receive medical care in any public healthcare setting without fear. Translated into 13 languages we have worked with Mayor's Office of Immigrant Affairs to promote this unwavering commitment to our patients through various mainstream and ethnic media outlets as well as signage in our facilities and multiple distributions to members of our staff. And lastly, we've also partnered with MOIA, the New York Immigration Coalition and the New York Legal Assistance to host immigrant health rights, panel discussions to help educate immigrant communities and provide access to information and

resources. These forums are underway now, and address a variety of important healthcare topics affecting immigrants such as healthcare rights, access to care, services and programs for immigrants and privacy concerns regarding immigrant status. I'd like to thank you Commissioner Johnson, Council Members Bill Perkins, Daniel Dromm, Mathieu Eugene, Carlos Menchaca and Borough Presidents Gale Brewer and Eric Adams for co-sponsoring these events. This concludes my written testimony. I and my colleagues are happy to answer any questions.

CHAIRPERSON JOHNSON: So [coughs] as I addressed in my opening statement, for the second consecutive year Health and Hospitals and the Office of Management and Budget have failed to provide a cash accrual plan for the Preliminary Budget season. Why didn't H&H release a Fiscal 2018 cash accrual plan ahead of this Preliminary Budget hearing?

STANLEY BREZENOFF: Somebody want to give it a shot? I'm going to—I have an answer, but I think I'd rather let PV answer.

CHAIRPERSON JOHNSON: Before I—before I have the answer, PV, if you all could raise you're your right hand. Do you swear or affirm to tell the

truth and nothing but the truth to this committee and respond honestly to Council Member questions?

PV ANANTHARAM: I do.

CHAIRPERSON JOHNSON: Great. Go ahead.

PV ANANTHARAM: So normally we—we decide to work on—

CHAIRPERSON JOHNSON: PV, if you could pull the mic a little closer.

PV ANANTHARAM: I am sorry.

CHAIRPERSON JOHNSON: There you.

PV ANANTHARAM: So we normally begin work on the Preliminary Plan around December, and this time around we were evaluating our actions below the line that Mr. Brezenoff mentioned about $79 million. A lot of the monies that we were supposed to receive were going to come in the second half of the year. So it was premature at that time to assess the viability of those numbers because at that time it was still in formulation. We've done all the work that was necessary, and the actions are starting to result in money. As—as Mr. Brezenoff mentioned, all the money is coming in now, and we are making good on our targets. So that was the reason why it didn't make sense to do an update to the Preliminary Plan.

CHAIRPERSON JOHNSON: So how much cash on hand can H&H currently report as of today or this month?

PV ANANTHARAM: This month we had around the 11th of March around $450 million of cash in hand.

CHAIRPERSON JOHNSON: And when the bills are paid at the end of the month what does that leave you with?

PV ANANTHARAM: As we have indicated in the Adopted Plan, it will be a little north of $100 million.

CHAIRPERSON JOHNSON: That's what you're projecting for the end of this Fiscal Year.

PV ANANTHARAM: That is correct.

CHAIRPERSON JOHNSON: So for—for the end of June?

PV ANANTHARAM: That is correct.

CHAIRPERSON JOHNSON: What was the cash on hand at the end of last fiscal year?

PV ANANTHARAM: It was around $440 million.

CHAIRPERSON JOHNSON: $440 million. So we're $340 million less. Why is that?

PV ANANTHARAM: Well, we've got a number of—so while we are currently projecting it to be $160 million, our efforts are intensified to aggregate a lot more savings in this current year, and we hope to do better, but our plan calls for us to end the year at around $160 million.

STANLEY BREZENOFF: If—if I may, Mr. Chair. So, cash is a—a changing position each—each week. So at the end of the year, based on what that—was going out and what was coming in we had $440. What we project at that moment in time at the end of this fiscal year, and it will quickly change depending on what revenues come in. It is around 100 and a million and change, but that's sort of what we hover at highs of around $4 or $500 million even our, and lows of approximately $100 million, but it quickly—quickly changes. Looking at the changes without looking at the—across a long period of time doesn't inform very much. We—effectively we used that cash from last—that was there probably very quickly. More revenue came in. Operating on a cash budget is—is like that, and over time we are—assure ourselves that we have the necessary cash to—to

operate. And, of course, cash is king so more is better, and we'll seek to keep increasing our cash.

CHAIRPERSON JOHNSON: So, $116 million, is that the number?

PV ANANTHARAM: That is the current plan yes.

CHAIRPERSON JOHNSON: The current plan. So how many operational days does that represent?

PV ANANTHARAM: That would be around six to seven days.

CHAIRPERSON JOHNSON: One week?

PV ANANTHARAM: That is correct.

CHAIRPERSON JOHNSON: That's a little scary, right?

PV ANANTHARAM: It—it goes back to what Mr. Brezenoff said, which is the vagueries of our cash flows. A significant part of our revenue sources rely on DISH and UPL payments. They don't often come on a consistent manner. So, depending on the week, day those numbers vary significantly.

CHAIRPERSON JOHNSON: So, we both talked about in our opening remarks the loss or the decrease in DISH funds that is going to go into place on October 1st of this year. How big of an impact does

that have on the overall fiscal health of the corporation?

STANLEY BREZENOFF: So it does have a big impact as—as you point out. It is a part of our planning for next year because we—next fiscal year because we have known about this possibility that—that has been a part of the ACA from the beginning. We're focused in—in Washington with our allies. This is a reduction that's been delayed, deferred, put off before with allies in a bipartisan way. This is an issue that has achieved bipartisan support in—in the past and we will be making stren--strenuous efforts with the—the New York Congressional Delegation, with our—our advocates and colleagues around the country especially with facilities and institutions in districts that have Republican representatives pointing to the fact that it's been bipartisan in the past, and there are legislative tactics and strategies that are being developed in Washington as the—the best way to proceed. You might asked if that fails we would be working again with our—our—our colleagues. We have some assurance to the degree there are healthcare funding cuts that affect New York while the legislature is not in session that a

special session would be—would be called to deal with—with them. We—we are relying on that, but we do think that there's a good deal of interest and—and concern in Albany about the effect of this cut if it were ever—the—the federal cut if it were ever to come into being.

CHAIRPERSON JOHNSON: So on the—in your testimony on the revenue side, you talked about $390 million in growing Medicaid revenue by participating in certain programs, which would generate $390 million increasing revenue from MetroPlus $102 million earning additional DSRIP payment funds $45 million, increasing the UPL funding the Upper Payment Limit funding $45 million, improving revenue collection through revenue cycle management $55 million and increasing reimbursement earned through HQFC status of your diagnostic and treatment centers $25 million. That comes out to be $100 million, $145—almost $700 million? What's the number? It's about $700 million?

STANLEY BREZENOFF: It's about $700 million.

PV ANANTHARAM: The total plan that's for $779 million. The difference between all of the

numbers that you read were the expense reduction initiatives that we have in place.

CHAIRPERSON JOHNSON: So, I asked because the Transformation Plan has a revenue generation strategy that relies heavily on state and federal funding. So is that realistic to have a $1.1 billion revenue generation strategy in this transformation plan given the current political climate that we're in, and given the numbers that you've already achieved or are projecting to achieve?

STANLEY BREZENOFF: So it's—it's obviously and on point the question given the environment that—that we're in, but first I want to note that the vast preponderance of the—the gap closing plan for FY17 was on the revenue side and much of it focused on the federal and state—state funding. We do not anticipate that all federal and state funding will—will disappear, and to that degree, achieving revenue targets are a part of our plans—will be a part of our plans going forward. Obviously, this is a—and—and we feel pretty confident about aspects of that—that revenue picture. Obviously, given the environment it's something that needs a close and continuing eye, and we need to be

planning for the potential of not—of not achieving it, but always strong advocate for it. So we're not prepared to surrender or throw in—throw in the towel, and we will have additional elements on the expense operational efficacy and revenue cycle side within the plan for the—for the future. But I—I must note that those dollars goals were achieved in FY17.

CHAIRPERSON JOHNSON: And what is the contingency plan if the corporation does not receive the anticipated funding?

STANLEY BREZENOFF: There is—well, I supposed that—that in thinking about that questions it's a question of how much is a—of a shortfall will we experience and—and when, and then we—we're—we're pretty good at identifying the potential for shortfalls and doing contingency, taking contingency steps. Right now we're finalizing our FY18 Plan of Action, and it will include both revenue and particularized steps that we will have to—that we will have to take, and we—we believe it will reflect a reliable picture of what can be achieved on both the revenue side and the on the operational—on the operational side. We will not be putting that pie in

the sky down as—as a part of—of what we see as closing our gap.

CHAIRPERSON JOHNSON: So, I—I mean I think it was great that you acknowledged and—and I want to do the same with the leadership of Dr. Raju, who took over at a very difficult time, and I think showed tremendous leadership, and I—he was a great person to work with. He and I had a great relationship, and we really want to thank him for his service. What I'm about to say is not a major criticism of him, but when you look at some of these numbers that you outlined and you look at, you know, let's just take on the scale of purchasing to track, it's on track to reduce spending on supply chain by nearly $63 million. That's a lot of money to—to save through supply chain negotiation, and it makes me wonder like why the hell weren't we doing that three years ago. If we can save that much money $63 million, why wasn't that being done earlier? It seems like a lot of money potentially is being wasted or not negotiated well.

STANLEY BREZENOFF: So, let me add to the weight of your question, but at the same time respond. Supply chain is one of the areas of

hospital operations that is a perennial target for improvement. I don't know of any system certainly none that I've run that hasn't been able to generate savings out of supply chain on a continuous—on a continuous basis. One can always argue about—and—and let me just add I believe that there are more savings that are available as we get better at supply chain, as we introduce support systems that will help us to better manage what has been a decentralized system in some—in major respects into a coherent whole. I'm going to be pointing to a supply chain for a continuous savings that will help us close—close our gap. I think in the particular, Health and Hospitals has been planning and is now in the process of implementing a system that I alluded to, ERP, which will give it the tools, give us the tools to better manage our supply chain from start to finish to a better standardized formularies and equipment so that we can maximize our clout in the—in the purchasing world, allow us to control inventory to do more just-in-time purchasing. So we're not spending money faster than we—than we have to. Supply chain offers all of that. It does require a rollout. Obviously in looking at these things we can say this about many

things in the world. The sooner one does it, the sooner one gets the—the benefits. Health and Hospitals always has a lot on its plate, always a lot of alternative investments especially on the capital—capital side. So finding the dollars for these investments has been a part of the judgment that management has had to—has had to make. I—I am focused on the fact that this is going to be come a reality, and it's going to be a real tool for saving money on a continuous basis, and—and make our burden—it won't eliminate our—the burden that you've alluded to, but it will put some of that burden in our hands where we can control our fate. I'll just add that the same can be said about revenue cycle. I don't know of a hospital system, Health and Hospitals among them that cannot find at any point in time savings even vast savings or vast improvements in revenue generating efficiencies in revenue cycle, and we're going to do that. We're going to make more investment in revenue cycle because the return is going to help us bridge that—bridge that gap, and Health and Hospitals really is not alone in this. Lots of hospital systems have to call them into question saying, damn, why didn't I do this—do this

before? It's sort of a common occurrence in some hospitals.

CHAIRPERSON JOHNSON: Thank you. I'm going to go to Council Member Eugene who has some questions. I was going to go to the bathroom. So I thought that Council Member Eugene could take over for a moment. [coughs] So on—on-on that point, Stan, this system is not like other hospital systems in the sense at least in our local ecosystem of healthcare in New York City the patient population and the principles that inform the care that you provide and who yiou see is different than some of the private hospitals or even some of the other non-private hospoitals in the city. Doesn't that affect these things?

STANLEY BREZENOFF: It-it does. It's—it's a—a if I may say—a—a terrific question. On the supply chain side, I don't think it makes that much of a difference. On the revenue cycle side, the universe of what we're working in is somewhat different. We don't have the same pair mix, the same case mix, the—the same insurance, but the principle is the—the same, and there is a lot of value there. Maybe not as much value as might exist in what you

might call a high end system, but the value is there. Where the patient population really makes a difference I think is in how we think about our mission, how we implement toward our—our mission. Baked into our organization, our culture, our workforce is this deep commitment to the fact that we serve patients many of whom have no other access to the healthcare. I noted the high number of behavioral health patients we serve. The number of uninsured patients that—that we serve. The commitment is on flagging. Generating revenue from the—the uninsured is difficult, and sensitive and highly limited in its—in its potential. So our efforts to make—help people be eligible, that's part of revenue cycle. Our efforts to deal with denials from insurance companies or even from Medicaid on questions of eligibility or—or care. That's a part of revenue cycle, and you can better prepare or better focused on those thing even for the people who start un—uninsured. So I'm going to say that the opportunities are the same in those areas, but they are there, and they offer lots of potential for-for us, and we will be focused on them in the coming year.

CHAIRPERSON JOHNSON: Are hospital closures off the table?

STANLEY BREZENOFF: They are.

CHAIRPERSON JOHNSON: Are significant layoffs of the table?

STANLEY BREZENOFF: As regards—as you know, there--

CHAIRPERSON JOHNSON: [interposing] There were manager—there were 70 managerial layoffs--

STANLEY BREZENOFF: [interposing] Yes.

CHAIRPERSON JOHNSON: --but I'm talking about broader layoffs.

STANLEY BREZENOFF: You're talking about on the frontlines?

CHAIRPERSON JOHNSON: Yeah, on the frontlines.

STANLEY BREZENOFF: No, there are no layoffs.

CHAIRPERSON JOHNSON: So that's off the table for now?

STANLEY BREZENOFF: That's off the table.

CHAIRPERSON JOHNSON: Is the privatization of certain services off the table?

STANLEY BREZENOFF: I—I'm tempted to give you a short answer and say yes it's off the table, but I don't always know what it means—people mean by that, and---

CHAIRPERSON JOHNSON: What I mean is I think Dr. Raju made a good decision in pulling back a decision that was going to privatize. So this is related to—why am I forgetting?

STANLEY BREZENOFF: Dialysis.

CHAIRPERSON JOHNSON: Yes, dialysis. Things like that.

STANLEY BREZENOFF: Okay so in all—in all candor and I just took the oath, right? We do have some dialysis services that are—are offered through sources other than Health and Hospitals. These are a—a couple of continuing the contracts. They offer a very high quality way, receiving high CMS ratings and recently—recently were extended. So there was an opportunity to—to stop it and seek to move to a—an in-house—in-house provision of the—the care, and I judge that to be a bad decision. This was such a high level, high performing service that received such high ratings, and the—the effort that would have been required and the uncertainty as to our level of

success and the additional expense caused me to decide not to, and to stick with the contracts that—that exist. So I want to give a qualified yes that there can be exceptional circumstances. This was one.

CHAIRPERSON JOHNSON: But the reason why I asked was questions they're not the only things, but typically what we see—and I'm saying they're the best methods. I'm not—I'm not saying I want you to do these things. What I want to happen is for the federal, state and city government to recognize the value of this public hospital system to step up in appropriate ways to keep the patient share that it needs to increase revenue, and to do all the things to ensure that its financially successful moving forward. But in the short term, the way that you typically save significant amounts of money are through the three things that I said: Closures, layoffs and privatization, and so if those three things by and large are off the table, and we are in a climate of political uncertainty as it relates to Washington, which then creates budgetary uncertainty for the State of New York and budgetary uncertainty for the City of New York, and budgetary uncertainty

for this public benefit corporation, I want to give you credit for the things you outlined in the $700 million worth of savings. That's enormous but I still don't feel a high level of confidence that we are on the best path for the financial health of the corporation moving forward so that some of those things may actually have to happen at some point. I mean we're saying no now. Part of that is—I'm not saying you're not being honest at all, but what I'm saying, you know, if you say yes there is going to be a fire storm. If you said oh, yeah, we're going to—we're actually looking to closing the hospital. There would be a fire storm. Oh, we're going to have massive layoffs. A fire storm. Privatization a fire storm. Understandably because that would affect patient care, the access to care for New Yorkers, good quality, high skilled jobs, all of these things. You're not a Dr. Stan, right?

STANLEY BREZENOFF: No.

CHAIRPERSON JOHNSON: Me either. [laughter] Dr. Eugene is. I—I would just love to, I would love to ask a doctor like if you were going to rate the healthy of the public hospital system, where would you give it on a scale of 1 to 10? The—the

financial health? If you were going to rate the financial health of this public hospital system on a scale of 1 to 10 of 10 being super, duper flush with cash and one we're in deep doo-doo, where are we on that scale?

STANLEY BREZENOFF: So we have a severe—a very severe cold and our job is to prevent it from going to pneumonia.

CHAIRPERSON JOHNSON: So that's like four.

STANLEY BREZENOFF: Yeah. So, let me—first I do want to say that we absolutely take it for granted that every question, every comment you make is gen—is in support of us and our--

CHAIRPERSON JOHNSON: [interposing] Yeah, it is.

STANLEY BREZENOFF: --our mission. No, we take-

CHAIRPERSON JOHNSON: [interposing] Totally supportive.

STANLEY BREZENOFF: --we take that for granted. You've been a champion for us for—for a long, long time. So here's the—there are tools that we have at our disposal, and I believe additional

tools that we can identify to close our gap for FY18. I am not exaggerating my absolute conviction that supply chain and revenue cycle offer tremendous opportunities for us millions and millions of dollars. Would they be enough? No.

CHAIRPERSON JOHNSON: Millions or tens or millions or hundreds of millions?

STANLEY BREZENOFF: Tens of millions.

CHAIRPERSON JOHNSON: Because we're talking about, we're talking about hundreds of millions that we need.

STANLEY BREZENOFF: Right, though I—I believe that—that some of our revenue programs will—will come through and we—we are identifying those, and we've been successful this year, and I think we can point to the—the success for—for next year, but I want to come to something else that—that will probably raise some questions as I—as I articulated and I want to note that we're—we're working on these and we will be back here in a matter of weeks on the—on the Executive Budget where these things are—including that the—the supply chain and revenue cycle will have more meat on the—on the description, but there are operational efficiencies that will ally

themselves with cost savings that will not rely on layoffs of—of front line individuals, and that will produce significant dollars on the cost side. And I'm not in a position to describe them because they're—they'd be half baked, but I based on my experience in—in hospitals, I believe that we can extract operational efficiency savings to combine with supply chain and the revenue cycle, and improve our financial circumstance.

CHAIRPERSON JOHNSON: Well, more—more questions on this, but I want to go to Council Member Eugene so we'll come back. How long have you been Interim President and CEO for?

STANLEY BREZENOFF: It's almost four months.

CHAIRPERSON JOHNSON: It's almost four months. How long are you staying for?

STANLEY BREZENOFF: [laughs] They haven't told me yet. No, interim is—is interim understood.

CHAIRPERSON JOHNSON: Are they doing a search?

STANLEY BREZENOFF: As—as far as I know that's what they—they told me they would do a search so—[laughter]

CHAIRPERSON JOHNSON: They might be lying to, Stan.

STANLEY BREZENOFF: it's not—let—let me just say. I wasn't—I wasn't looking for this job, but it's not the worst job in—in the world. I mean, let—it is--

CHAIRPERSON JOHNSON: That's a very high standard. It's not the worst job.

STANLEY BREZENOFF: Well, I'm—I'm saying this in relation to the fact that it is a mission driven organization.

CHAIRPERSON JOHNSON: You get to help a lot of people.

STANLEY BREZENOFF: Once an HHC person, which I was. Where's Anna? I said HHC because it's a start, and a Health and Hospitals person, always a Health and Hospitals person. I'm not alone in this. There's a small cadre of people who feel a deep commitment to the organization and its mission. What it's planning to do is as important as what it has been doing. It's recreating itself to meet the new

needs that are emerging. The—the threat from Washington. The change in reimbursement policy. It's never been more important than the work it has to do. It's a privilege to be—to be a part of. So I'm not crying about—about being here.

CHAIRPERSON JOHNSON: [interposing] See if you can find that job listing posted somewhere. [laughter] They might have tricked you. Okay, we're going to go to Council Member Eugene.

COUNCIL MEMBER EUGENE: Thank you very much, Mr. Chair. Thank you. Mr. Brezenoff, thank you very much for your testimony, and to all the members of the panel I thank you also. Thank you very much, and I know Mr. Brezenoff your dedication and passion, you know, to serving the health area, and I know your track record. You have been there doing it. This is something that you love, and I know you way before I was elected, and I'm witness of, you know, the wonderful job that you have been doing that you have done in the area of health. And I want to take the opportunity also to commend and thank all the great people, the wonderful staff from Kings County regarding HHC also and their leadership for their wonderful remarkable jobs. You know what

they have done to improve the idea of your science program at Kings County, and I'm so delighted that—that you as Department of Justice, you know, ended the oversight of Kings County, and they declared that the preference—the improvements exceed the expectation. This is remarkable. That should be commended, and I'm so proud of it because Kings County is in my district. [laughter] I'm so privileged, but I got probably one or two questions for you and for the members of the panel. We know that HHC is a wonderful institution. As a matter of fact the job that you have to do is huge, it's critical because this is an institution that is providing some medical care to everybody as we know regardless of ability to pay, regardless of immigration status. This is a big task, but I had one concern, which is about natural disasters and emergency. My question is I don't know if we in New York City we are ready for big huge natural disasters emergency because I remember Sandy, after Sandy that was a big blow. I don't think that we were ready for that, and I went to visit I think it's Beth Israel by [laughter] by—by Kings Highway, no?

STANLEY BREZENOFF: Yes.

COUNCIL MEMBER EUGENE: Kings Highway. Now it's—it's being taken over by another hospital.

STANLEY BREZENOFF: Yes.

COUNCIL MEMBER EUGENE: What is it?

STANLEY BREZENOFF: Yes, Mount Sinai.

COUNCIL MEMBER EUGENE: Mount Sinai. Yes, I went to visit that hospital. When I went to the emergency section what I saw I was shocked. So many people. Patients close to each other's scratching and coughing, and the doctors and nurses they try to get through it to go from one side to the other side because Coney Island Hospital, you know, was in trouble. They had to transfer their patient to Memorial Hospital into Mount Sinai. But my question is if there's a big catastrophe, big disaster in terms of medical services, are we ready to provide the necessary medical services to New Yorkers? Are we ready to do that?

STANLEY BREZENOFF: So, before I respond to that, it's a really important question for-for us and for the—for the city, I want to note how much of a champion you have been Councilman for Kings County Hospital and how important your advocacy has been to the success of that—of that institution.

COUNCIL MEMBER EUGENE: Thank you.

STANLEY BREZENOFF: So, nothing is more fundamental to our—our mission than our ability to provide services in times of critical need like emergencies. So first, in regard to Sandy and its aftermath particularly we were hard hit in a few of our facilities which underscored our vulnerability and since Sandy Health and Hospitals with the support of FEMA dollars has been engaged in substantial focused efforts to assure that our facilities are not vulnerable in the way that they were for—in—in the wake of that—of that storm. Coney Island in particular has—is in the process of essential rebuilding, strengthening, buttressing and I'd be happy to share details with you because Coney Island was the—the trip wire for what happened to several other hospitals as a consequence. As—as you note, we were also affected at Bellevue at Metropolitan and at Coler we were threatened and clearly vulnerable—our vulnerability was demonstrated at those—at those institutions. So we are working with the City Office of Emergency Management using FEMA dollars to upgrade those facilities that were affected and were demonstrated to be vulnerable. On a broader scale the

City itself is—the city government the Administration is very focused on these questions and has—has brought together and continues to bring together to comprehensively plan across agencies to deal with these kinds of disasters and the broader hospital world because there was some voluntary hospitals that were significantly affected. They NYU adjacent to—to Bellevue. So the Greater New York Hospital Association is—is coordinating shared response, mutual support for all hospitals. Our goal has to be that we are going to operate, function serve no matter what the emergency is and in the even that some of our institutions have to provide backup, we're in a position to do that, and that's very much what we are focused on and have been planning for.

COUNCIL MEMBER EUGENE: And thank you very much. I'm glad that you mentioned coordination because I remember I was—I went—I was walking through my district, and I went to one of the nursing homes, and probably there are more than one in the city. Ambulance couldn't—couldn't get through to reach out to the nursing home to get close to pick up, you know, a patient who are in a critical situation and because of the snow, I think it was snowing at the

time I believe, you. And in many occasions there were other people who were suffering from diseases that need critical care and urgent care. There were no way to reach out to them, and to bring them to hospital. It's only plain, you know, to try to keep (sic) them and overcome those changes, in case if there is a natural disaster or tragedy, and also coordination between the hospital and medical center.

STANLEY BREZENOFF: So important to an issue like that, which is critical of the—it goes to the heart of life safety, is the communication system and the response that's possible. It—it requires the ability to feel to assure that the problems and issues are going to get to the right point, and the ability overall across the city to respond to those problems. We could enumerate lots of possibilities. The immediacy of getting an ambulance, getting fuel oil, possibly water supplies, even other kinds of supplies through affected facilities. Sandy was a learning experience for the city, which had a very high quality emergency management response apparatus. Sandy taught us that we—all of us had to do more, had to focus more on better communication, had to establish the ability to have resources readily

available, and to have trained personnel in all of these things. Dr. Allen, could you say a word about the training that has been going on?

DR. MICHELLE ALLEN: Yes. My name is Dr. Allen. I'm the Chief Medical Officer for Health and Hospitals. We actually have ongoing regular tabletop exercises. As you pointed out, it requires coordination with other New York City agencies, the Office of Emergency Management, FDNY, et cetera. Actually, as we speak this week, Lincoln Hospital will be doing a table top exercise on hurricane preparation and in April we'll be doing a citywide exercise for an emergent pathogen in collaboration with CDC, the New York State Department of Health, New York City Department of Health, OEM, and FDNY (sic). So emergency management preparation is key to us, a priority to us. We work with other city agencies, and we're constantly preparing and doing exercises in the event we have another catastrophe.

COUNCIL MEMBER EUGENE: In the budget of HHC do you have a—a part of the budget, a portion of the budget designed to emergency situation to improve the emergency—the emergency response?

STANLEY BREZENOFF: The—the answer is yes we—yes we do. It's [background comments].

PV ANANTHARAM: I can't give you numbers at this point in time, but it is a definite division focused solely on being prepared for emergencies.

STANLEY BREZENOFF: And we'll—we'll provide you with those—with that.

COUNCIL MEMBER EUGENE: Thank—thank you very much because we are living at a very special moment now. This is a very special time. We don't know what's going to happen. We hope that everything will be alright, but if God forbid we have a major emergency, we should be able to provide the necessary care to the people who are going to face the emergencies, and I would suggest the—the organization to put enough funding for HSC. You know for you to be able to serve people in case of emergencies. Let me ask my last question. I know that Kings County Hospital is one of the trauma centers. You I think-I think we have three or four--

STANLEY BREZENOFF: Uh-huh.

COUNCIL MEMBER EUGENE: --IN THE CITY OF New York, but I witness every single day people go to Kings County almost every single day, all these

officials, children, people, you know. The situation they are facing right now is critical. So is there any way that the Administration can, you know, the Administration, you know, it's just it can work together with Kings County to make them more efficient in terms of providing care to the people in case of traumas because I believe that at one time I went to Kings County there was a big tragedy in my district. Three children from the same family the house was on fire Kings County they start giving them the critical or the first assistance, but they had to transfer them I think to Manhattan or somewhere else because they were not equipped to continue to give them cares. I would appreciate if you—if just we can work together with Kings County, and see what they would need to improve their capacity to respond to a trauma situation. Is there anything that Kings HHC or the Administration can do to work together to make this county more capable to respond to trauma situation?

STANLEY BREZENOFF: We—we're very proud of our trauma capability at Kings County and throughout the—throughout our system, but obviously we're always eater to improve the level and extent

and efficiency of our services. So I'm going to take advantage of you somewhat and ask that we make some time to follow up and focus on—on what you're thinking about. I do want to say a word about the—the Burn Unit part of your—your question. The Burn Units that exist in the—in the city, and you're right, burn—burn victims would get that—they'd be stabilized. They'd be resuscitated and then be transported. The existing Burn Units have lots of capacity. It's established, accepted best medical practice to transport burn patients once you've done the basic things to centralized burn units where you can concentrate the resources and the staffing and you can handle the volume as opposed to having very, very low volume in a large number of—a large number of places. So Manhattan and Staten Island both have burn centers. There are actually a couple in—there's one in Manhattan, and there's one in—in the Bronx. So for purposes of high quality service and for better consolidating volume where you can have expertise and the ability to handle burns, it—it doesn't really make sense to—to think about a Burn Unit at Kings County. But other enhancements or improvements in how we operate you're entirely open

Councilman, and I—as I say I'm going to take advantage of your interest, and arrange for some further discussion about the ways we might do that.

COUNCIL MEMBER EUGENE: Thank you very much, Mr. Brezenoff, and thank you to the members of the panel. Mr. Chair, thank you very much.

CHAIRPERSON JOHNSON: Thank you and I want to recognize Council Member Eugene. I know that Stand Brezenoff did it in his testimony, but you have done such a champion for not just Kings County Hospital, but the other hospitals in your district, and not even just in your district, in the whole Central Brooklyn area, and your advocacy every year is really meaningful. So, I want to thank you. Okay, I want to get back to some question. I don't want to keep you too long because the public has been waiting all day, and we—we are—we're going strong, but I'm—I'm going to rifle through these. Okay. In the Fiscal 2017 Administration OMB projected $1.3 million-billion of an operating gap for Fiscal 2017 growing to $1.8 billion for Fiscal Year 2020. In Fiscal 2017, HHC, as you said earlier, aims to close that gap by al the things you identified and expects to have $118 million in cash on hand or savings. So

I still don't understand how we eventually—we talked about supply chain and revenue and all that stuff earlier. How do we get from where were are now in the next three years to close a $1.8 billion gap? That's the $1.8 billion question.

STANLEY BREZENOFF: So, I think we can address it in a possible sense. Talking about 2020 is a little bit of a curve ball in the immediate. We're—we're on a—a plain, an upward sloping plain, both in terms of need, and in terms of our efforts and our ability to—to manage revenue and cost. So some of our planning and focus is low on term. When we talk about the DSRIP and—and transformation, we're not talking about the short term. We're expecting to rethink and remodel, re-envision, restructure what we are, how we do it, and what the economic realities will—will be. Frankly, my assumption as a healthcare administrator is that reimbursement policy eventually and probably parallel to DSRIP will have to change because DSRIP really envisions our system becoming less focused on inpatient care. Which is where all the reimbursement now goes and more on prevention, population health, wellness, management of care, utilization of managers. Most of the stuff for which

we don't get paid very much at all, if—if anything. DSRIP is cushioning that as we—as we do it, but if at the end of the day nothing changes, then honestly I don't know what this is all about. I believe that we need to get through these next years, manage the—the deficits through a combination of things, get the benefits of—of DSRIP funding and we hope changing—changing reimbursement, and reducing outlays that don't make sense any more as we're—as we're changing. And how that play out over the—the-the four our five years, I think that's still to be developed, still to emerge, and as of this moment, and somehow we have to count on whether it's from the feds or the state some continuing—continuing subsidies. To the degree subsidies disappear, then we're going to have to go back, sharpen pencils and—and—and focus on options and alternatives. But I do believe we will have a path for FY18 that like '17 will have a foundation for '19, but the—the job gets tougher as you noted, in fact, when you talked about the—the-the measures that are at our disposal and the limitations on those measures. It does get tougher, but right now I think in our sights we're going to be successful FY17 and we have a route for FY18.

COUNCIL MEMBER EUGENE: The transformation plan also included $306 million in expected revenue for the Federal Waiver Program for the uninsured.

STANLEY BREZENOFF: Unlikely.

COUNCIL MEMBER EUGENE: Did that come through?

PV ANANTHARAM: As part of the—as part of the reductions and vision in the DISH program, the attempt was to convert some of our DISH dollars into waiver programs to try and get the federal government to pick up the cost of some of the uninsured.

CHAIRPERSON JOHNSON: Did that happen?

PV ANANTHARAM: That did not happen. The—the unexpected turn of events in Washington was not expected so—but we did make up for that in ’17 through a lot of other initiatives. So we met the targets for ’17. We are still working advocacy programs for ’18 in terms of DISH reductions. So those should hopefully offset some of those issues.

CHAIRPERSON JOHNSON: So I just—and I say this in respect really I do. I’m not trying to pile on or belabor a point because I—as I know I care about you all, and I want to do anything I can to

support you all, and continue the mission. That right there speaks to me of sort of a microcosm of the much bigger problem, which is we—we make assumptions, which are not bad assumptions, given what the political climate was when this budget was adopted when the transformation plan into place. I don't think they were wrong assumptions. We make assumptions of $306 million. That's a lot of money. That's three times the amount of cash you project to have on hand at the end of this fiscal year, and then it didn't come through.

STANLEY BREZENOFF: But we did make up for it this year.

CHAIRPERSON JOHNSON: You did make up for it, but if things keep happening like that where these very large chunks of revenue are based on things that are outside of your control, and they don't come through, it continues to imperil the limited options that you have and makes even more difficult choices present themselves to you on a shorter time horizon. I mean it just speaks to me of how—how hard this is.

STANLEY BREZENOFF: And how fragile our situation is.

CHAIRPERSON JOHNSON: Yes.

STANLEY BREZENOFF: So, I—I agree, but we're not there yet. We have, as I say a path for FY18. I take some heart in the fact that the call that some of our leaders have made to organize, to resist, to fight back, to make allegiance with similarly situated facilities and caregivers across the country some of whom don't have—you know, have the in vogue legislatures representing them who are on the other side of island. Maybe energize them to mitigate some of the missed (sic) for it. Make up for some of the issues because DISH is a popular program in lots of places. It is really conceivable. It is doable in my mind to have a—a successful alliance that can do something about the DISH cuts in—in Washington. But I take your point. That's not going to stop the threats. These characters hate Medicaid. The most important healthcare instrument created in the history of this country actually. More so even than—than—than Medicare. They hate it. They will do whatever they can to—to destroy it. They will have enormous—if they succeed, if we can't stop them, it will have enormous implications for the state budget, the city budget, for healthcare

deliverers, for people on the—the receiving end. So it has to be resisted. We have to fight it, and we can't throw in the towel. I do believe that whatever happens we'll figure out the best way to deal with that. But the threat is real. I—I can't discount that.

CHAIRPERSON JOHNSON: Okay, I'm not—I'm not going to keep going question by question on—on the financial stuff because I think we'll keep having the same conversation, but I look forward to having more documents--

STANLEY BREZENOFF: Okay.

CHAIRPERSON JOHNSON: --not a few days before the Executive Budget hearing, but a few weeks before it or a month before the Executive Budget hearing so that we have time to look at the Executive Budget plan [coughs] and to come back and have an even more detailed conversation because maybe more will be figured out in Washington in a good way or a bad way or it may still be unsettled. [coughs] So my hope is that we can continue to have this conversation moving forward.

STANLEY BREZENOFF: That's clear. That's vey clear.

CHAIRPERSON JOHNSON: Okay.

STANLEY BREZENOFF: Thank you.

CHAIRPERSON JOHNSON: So, just a few things. Access to care. H&H integrated abortion care training into its obstetrics and gynecology residency training programs in 2001. However, advocates have alerted us that changing staffing have resulted in conditions that undermine abortion access at H&H facilities, and how does H&H evaluate the provision of abortion services at H&H facilities. How can H&H improve the delivery and accessibility? If you go to H&H's website, and you type in abortion, you don't get one hit. You get nothing. At least when we did it, right? Go to your website and you don't find one page, one piece of information on how someone would have access to abortion related services. That's a problem.

STANLEY BREZENOFF: So there's a lot to follow up on, and we will follow up on. You learn something in these—lots of things in these hearings. So we will follow up on that, but I'd like to ask Dr. Allen who—who knows a good deal about this.

DR. MICHELLE ALLEN: So we offer—we do offer abortion services at all of our facilities.

Thanks for bringing it to our attention that they're not advertised on our website. We'll look into that. Everyone of our facilities that has an OBGYN residency program has training on abortion services, first trimester, mid trimester up to the legal limit of 24 week. We work closely with DOHM to make sure all of our patients have access to contraception and family planning. We participate in Title—Title X Federal Funding for Family Planning Services. In those facilities, those few facilities that don't receive Title X funds, we've worked with DOHMH to make sure that long-acting reversible contraceptions are available to all patients. We also work closely with Planned Parenthood, as you mentioned in the previous Council hearing with DOHMH. We're very concerned with this administration and their attitudes towards reproductive health services, and we plan to make sure we have the capacity for the women of our city who need those services.

CHAIRPERSON JOHNSON: Does H&H still provide comprehensive abortion training in OBGYN residency programs.

DR. MICHELLE ALLEN: As I said earlier, every program that has an OBGYN residency program offers abortion training.

CHAIRPERSON JOHNSON: So just because I want to just repeat this. The services listed under women's health on the H&H website include managing diabetes, treating asthma, quitting smoking, but not abortion services. So can we change that?

STANLEY BREZENOFF: You've alerted us to a problem. We will correct.

CHAIRPERSON JOHNSON: Great. So we're going to correct it. Great. Let me see. [background comments] I want to talk a little bit about Correctional Health.

STANLEY BREZENOFF: Okay.

CHAIRPERSON JOHNSON: So maybe Patsy can--

STANLEY BREZENOFF: So Patsy, maybe you can join us. [pause]

CHAIRPERSON JOHNSON: Patsy, do you affirm to tell the truth?

DR. PATSY YANG: Yes.

CHAIRPERSON JOHNSON: Thank you. Okay. The total number of Correctional Health clinical

visits including intake exams, sick calls, follow-up visits, mental health appointments and dental visits decreased by more that 14,400 visits in the first four months of Fiscal 2017 compared to the same period of last year representing a 6% decrease. Does this decrease indicate a healthier patient population or a reduction in health services or neither?

DR. PATSY YANG: I'm sorry. Am I on.

STANLEY BREZENOFF: Yes, you are.

DR. PATSY YANG: Okay, thank you. Probably a combination of several things. Some—one—one of which is the census in which ours has been dropping.

CHAIRPERSON JOHNSON: If you could speak up a little.

DR. PATSY YANG: Sure. I'm also—it's over here. So I have a terrible cold so. So the census in the jails has been dropping, but the patients who remain the jails have higher needs both in terms of acute and chronic medical needs, and mental health conditions. The actual percent of—of individuals in the jails has—with mental health issues has risen from Calendar Year 14—it was 38% to Calendar Year 16 with 43%. We've been able to refocus our resources

to deal better with the higher needs of our patients. So it's yes and a no.

CHAIRPERSON JOHNSON: Legal service providers have expressed concern that some detainees have been unable to access their medical appointments in a timely manner due to the system's reliance on paper records. Does the transition to electronic health record platform Epic include upgrades to the—the Correction Health System?

DR. PATSY YANG: We currently have been and we have been for years our electronic health system having contact with hospitals. Our plan long-term is to actually get in line and queue to move over to Epic, but we are at the end of the queue having been the last to come on board. So we use electronic records. I'm not sure what the—what the question is or the delay relay related to paper records.

CHAIRPERSON JOHNSON: Well, we were told that the—are there no paper records that are used at all on any of the systems that you all use on Rikers?

DR. PATSY YANG: There—there are some related to pharmacy. There has been paper exchange between Elmhurst, Bellevue, and us when we send

patients to for example Bellevue for specialty care, in-patient care. It's equally Elmhurst. Having come again to Health and Hospitals we've arranged for view only sites from both sides so that Bellevue and Elmhurst can view our records, and we can view theirs. That has been a good augmentation to the historic traditional thing of putting people—people's records on paper.

CHAIRPERSON JOHNSON: I have so many questions, and I don't say that in a negative way. I just feel overwhelmed with the amount of ground I want to cover both on Correctional Health Services and generally on Health and Hospitals related stuff that you guys do. But I don't want to hold the public up here all evening and all night. Many of them have been here for hours on end. So I am going to ask five more minutes worth of questions, and then I am going to give all of these questions to your teams, and my hope is that these questions can be answered in a written response before the Executive Budget hearing. So I don't run into the same issue of not having enough time to answer the questions, and not having it on the record in a public setting.

So do I have your commitment to have these questions answered?

STANLEY BREZENOFF: Absolutely.

CHAIRPERSON JOHNSON: So I—I want to stay quickly on Correctional Health, and I'm going to try to—if we can just get through this really quickly.

STANLEY BREZENOFF: Okay.

CHAIRPERSON JOHNSON: How many inmates are currently enrolled in a 90-day drug regiment of Hepatitis C treatment in the City's jails? I know you guys are ramping up your $5 million—a $5 million commitment to take care of inmates with Hepatitis C.

STANLEY BREZENOFF: Right.

CHAIRPERSON JOHNSON: How many folks are being treated currently?

DR. PATSY YANG: I think we've got about 60 on there. Yeah.

CHAIRPERSON JOHNSON: Sixty?

DR. PATSY YANG: At this point. It's not to miss the school year. (sic) Thirty per day at any point in time, but the new enrollees are about 60. So at any point in its 30--but we are still in that first year of expansion where we'll proposing to triple the number of people we can treat.

CHAIRPERSON JOHNSON: Great. So one thing I'd like to learn. We don't have to talk about it now, but I'd like to—to hear from your team if there have been challenges in expanding Hepatitis C treatment in the jail system, and if there's anything that we could be doing to help ease that process with DOC in—in getting more people the treatment that they need while they are actually on the island getting them a 90-day regimen and hopefully curing them of Hepatitis C as many people as possible.

DR. PATSY YANG: Okay.

CHAIRPERSON JOHNSON: So, this Administration has generally supported a harm reduction strategy and healthcare policy in programming including syringe exchange access to help prevent the spread of Hepatitis and help prevent the spread of HIV. If you could. You don't have to answer it now, but if you let us know what the Division of Correctional Health Services is doing to integrate harm reduction strategies into your daily operations. So given the population on Rikers Island, given the issues that we're seeing there, what strategies are you all doing to incorporate harm

reduction in the services and healthcare that's provided?

DR. PATSY YANG: Sure. Specifically on HIV and Hep-C our--

CHAIRPERSON JOHNSON: [interposing] I mean I'm sure there are others that you guys could come up with but HIV and Hep-C would be a good place to start. In December of 2014, MOCJ and the Task Force on Behavioral Health outlined $134 million in spending to reduce the number of people with behavioral issue cycling through the Criminal Justice System. I think the name is Frequent Fliers, people that are coming in and out of Rikers over, over and over again. The plan included $38 million in Fiscal 2015 through Fiscal 2019 for release and re-entry programs including connecting inmates to Medicare. Sorry, Medicaid. In an average year, do you know approximately how many inmates with mental health diagnoses are receiving discharge planning services?

DR. PATSY YANG: I can get that for you.

CHAIRPERSON JOHNSON: Okay, that's really important. I want to know to date how many inmates has Correctional Services connected to Medicaid--

DR. PATSY YANG: Okay.

CHAIRPERSON JOHNSON: --and enrolled through Medicaid. I want to know if it's possible to track inmates with mental health issues post-release in order to assess the effectiveness of these initiatives? Is discharge planning working? Is connecting to Medicaid working? Are we doing care coordination? Are we following up after the discharge to make sure they're seeing a psychiatrist, they're seen whether it be a parole officer or a case manager to get the help that they need post-release? That's important. I have a lot of questions about people with disabilities and access to care on Rikers Island. In talk about that I'll get you those questions. I have a bunch of questions about pre-arraignment screening about how they're being screened pre-arraignment and how that's working.

DR. PATSY YANG: It's working now. Thank you.

CHAIRPERSON JOHNSON: I have a bunch of question about the ESH units, Enhanced Supervision Housing units, and people with mental health needs and cognitive or intellectual or development disability issues. How has that been for them? How are they being assessed by your team?

DR. PATSY YANG: [interposing] Great.

CHAIRPERSON JOHNSON: If it's having an adverse impact on their mental health, if it's helping. So I have questions there as well. So we have a lot of questions, but I want to—we'll get these to you. I want to say similarly they're not on the same scale. Patsy, you—I don't why you took that job. [laughter] It was a hard job getting Corizon off the island, staffing up, doing the background checks, hiring new staff, getting rid of stuff that didn't work, transitioning from daily (sic) and doing the Bar and all these stuff to—to—to doing this job. It's a huge job, and it's an important job. It's one of the most vulnerable populations in the City of New York. It doesn't grab political headlines unless something really bad happens, but it's incredibly important and the work that you all are doing providing healthcare to these inmates, I'm not going to say it's perfect because I don't know if it's perfect because I don't know if it's perfect, but it's important, and I am grateful that you have spent 2-1/2 years?

DR. PATSY YANG: One and a half.

CHAIRPERSON JOHNSON: On that?

DR. PATSY YANG: One and a half years.

CHAIRPERSON JOHNSON: So you've spent--

DR. PATSY YANG: [interposing] It seems like—it's like longer, but one and a half.

CHAIRPERSON JOHNSON: So however long you've spent, you've spend a long time getting this off the ground, getting it up and going. There are much larger issues at Riker that are—Rikers that are way beyond your control like who ends up there, why they end up there, should they be there, and the conditions on Rikers Island itself, which are DOC issues and not Correctional Health issues, which makes it even more difficult to deal with these issues because they're outside of your control and purview, but I think we're going to have a hearing on Correctional Health this year specifically on Correctional Health, and we haven't set a time yet. We'll talk more about this in the Executive Budget hearing, but we're going to get you a lot of questions, and if you could get us substantive, thoughtful complete answers to these questions in advance of the—the Executive Budget that would be great.

DR. PATSY YANG: Will do.

CHAIRPERSON JOHNSON: Thank you very much. Okay, Stan, I want to end with this: Oh, Patsy just one other quick thing. You guys have requested a bunch of variances from the Board of Corrections. There have been—I have—I have some March 10th letters requesting variances on BOC minimum standards regarding seclusion, Section 206.

DR. PATSY YANG: Uh-huh.

CHAIRPERSON JOHNSON: I mean I want to learn more about this and why you need these and what's--

DR. PATSY YANG: [interposing] Happy to do it.

CHAIRPERSON JOHNSON: --reasoning behind getting these variances from the Board of Correction, and if they're temporary or if they're long-term and what's the plan to actually take care of the underlying issues so you don't need to keep seeking variances, but you fix the problem.

DR. PATSY YANG: We're happy to do that in whatever form you wish.

CHAIRPERSON JOHNSON: Okay, great. Okay, so Stan, I just want to end with [pause] so again, you don't have to answer these. I just want to run

through the issues that—that we want answers on. So there are some Family Court issue, HHC mental health clinics have worked with the New York City Administration for Children services to conduct mental health assessments in Family Court cases. Experts are telling us that they found the clinics' evaluations often failed to meet half of the essential professional criteria from the American Psychological Association, and other professional guidelines. That's a problem. So we need to make sure that whoever is in charge at H&H of conducting these assessments with ACS at Family Court we want to ensure that—that they're doing it in the most professional way, they're getting accurate assessments because these assessments in many ways are what are determining how judges are making decisions based on families' needs, and we don't want children being separated from families if they don't have to be separated, or children staying with families if it's not the appropriate fit or role. This has become a big issue. Advocates are all over it, and it's something that I would actually like for you to look into and address before we have the budget hearing, but actually in the next couple of

weeks to figure out how we figure this out if there's—if there's an issues.

STANLEY BREZENOFF: It the first I've—I've heard of it. We will look into it, and we will get back to you before the Budget.

CHAIRPERSON JOHNSON: Okay. I just want to just—I don't want to again belabor this point. Eighteen hospitals have closed in New York City since 2003, which leaves 61 hospitals currently in operation, and most of the hospitals that closed are the ones that were treating the poor, helping the poor, you know, not requiring that people come in with insurance. Saint Vincent's Hospital two blocks from where I live up open 161 years closed. That was a level 1 trauma center, a key place. It never should have been allowed to close, and I want to understand if—if these consolidations and closures present opportunities for increased hospital utilization at H&H facilities. So with all these closures does that actually open up a larger patient pool that you all could potentially capture that we're being treated in the past at other places but now may not have the same access to care and that's a population that you guys know how to treat or

treating right now. But maybe a larger patient share that you tap into. So I'd love to learn more about that. Three top executives at Jacobi Medical Center recently vacated their positions. The CEO, the CFO and the Chief Medical Officer. I'd like to learn why that happened.

STANLEY BREZENOFF: I'd be happy to if I might indulge the Chair since—since they're personnel matters.

CHAIRPERSON JOHNSON: We can about it—later about it.

STANLEY BREZENOFF: Okay.

CHAIRPERSON JOHNSON: There's an issue of malpractice claims. The Controller's Annual Claims Report said that there were 885 claims against H&H in Fiscal Year 2016, which is down from 905—905 the year before. However, while the overall number of claims decreased, the number of medical malpractice claims filed against acute care hospitals increased 6%. So I'd like to learn about kind statistically looking those claims, why is it happening? Are there things that could be done? Were there legitimate claims to ensure that that doesn't happen in the future because it cost the corporation a significant amount of money

through litigation and through, you know, trying to resolve those. Last year Mayor de Blasio signed a contract with Manatt Health a division on Manatt Phelps and Phillips to help H&H implement a strategic plan, manage government programs and stabilize the healthcare system. I'd like to know the kind of status of that work, are they done and does the city intend on extending that consulting contract with Manatt Health moving forward as it continues the Transformation Plan. I want to learn about Epic, where things stand with Epic with the rollout, getting it in all the hospitals and all the diagnostic treatment centers and other facilities that H&H operates right now. I'd like to learn more about the One City Health PPS through DSRIP that you guys have worked on and new needs. I know that there were some new needs related to Correctional Health and through compliance reporting over there, and there's more. So I don't want to keep going, but there's—there's a lot more, and we don't have enough time, but I don't know if you want to say anything on any of those, but we should keep talking.

STANLEY BREZENOFF: I think that's the key. Some of those subjects they're all important,

are complex and probably worth even separate discussions. So depending on you time in addition to answering particular questions and providing information I think we should look to having some separate discussion about some of the more weighty and complex matters that—that you talked about, and we'd be happy to do that.

CHAIRPERSON JOHNSON: Okay.

STANLEY BREZENOFF: And it will be ready in the Exec.

CHAIRPERSON JOHNSON: Okay. So I'm glad that everything is great and simple and easy at both Correctional Health Services and H&H, but I am grateful for the work you all are doing. I applaud you for the progress you've made thus far. I think we've talked a lot about the fragility and the position that you all are in. It's my hope that through the work you talked about that's being done in Washington and creating coalitions to stave off some of the most draconian cuts that could come down the line, as well as having the State Legislature do as much as possible to continue to look at reimbursement rates and safety net providers and all of those things. And with the city, which has

really—the de Blasio Administration deserves credit for last year's stepping up in a significant way when things were extremely precarious and taking over the malpractice insurance, and supplementing the cash on hand that was necessary to keep H&H out of the red. All three of these things I think are vitally important, and us working together moving forward so that we as a Council can know what's going on in a transparent manner, but also to support the work and continue to ask the difficult questions that the public wants to know about moving forward I think is really key. So I appreciate your testimony. I appreciate you being here and your patience, and I look forward to having continuing conversations in the weeks to come even before the Executive Budget Hearing.

STANLEY BREZENOFF: Me, too. Thank you very much.

CHAIRPERSON JOHNSON: Thank you very much. So, forgive me. We're going to take a five-minute recess. We're going to come back and we're going to get to the public, and everyone who came to testify is going to be able to testify. Okay. [gavel] [recess] [background comments] [coughs]

[gavel] So we're going to resume the Preliminary Budget hearing for the Health Committee. We have seven panels of people, and many of you were waiting a very long time. So I appreciate your patience in coming here and to testify. It's really important that we hear from the public. So everyone is going to have the opportunity to testify. May I just say one thing before I call the first panel up? If—and this is fine if there are organized groups of people that are here on the same issue, no matter what the issue is, you know, try not to—you don't have to repeat the person before you or say the same thing that the person before you said. You can say something different on the same issue or you could say I agree with most of what the person said because we're going to keep everyone on a strict three-minute clock. You can still submit testimony. We'll look at the testimony. We'll enter it in as part of the record of the Preliminary Budget hearing, but if folks could stay on the three-minute clock and at three minute when I cut you off I'm not being rude. I'm not being mean. I'm not saying I don't care what you have to say. I just want to make sure that everyone has the opportunity to testify and there

will—and we're happy to—to take your testimony and have conversations with you as well. So we're going to start. The first panel is Suzanne Robinson-Davis, from the Bedford-Stuyvesant Family Health Center, and again, forgive me if I don't pronounce your name correctly. Don't forgive me if you have bad handwriting. Maha Altia—Altia. Hi. Alexis Posey and Claudia Calhoun. [pause] [background comments] That's okay. That's alright. Okay, you may begin in whatever order you'd like. Just ensure—be sure to state your name for the record when you start. So why don't we start here. Make sure the red on the mic is on.

MAHA ALTIA: Good it's on. Okay. Good afternoon, and thank you to the Council Health Committee for giving us the chance to speak on behalf of our communities. My name is Maha Altia. I am the Health Program Manager and New York State of Health Navigator at the Arab-American Family Support Center since 2003. We are a non-profit and supplement house operating out of six sites throughout New York City and serving over 6,000 clients every year from the Arab Middle-Eastern Muslim and South Asian immigrant communities. Our health program connects our clients

to free and low-cost health insurance and we provide and the care to our providers whose speak our clients' languages. Under the Affordable Care Act we have been one of the few Arabic speaking health navigators and all the Arab-American city or as navigator site in New York State. In 2015, we enrolled 1,147 individuals. In 2016, we enrolled 1,245 individuals. Our numbers increased because of the outreach to through the community New York—New York Access Health Funds. The majority of who we are—we serve low-income Arabic speaking. They sign up for health insurance. Funding form Access Health New York City has allowed us to work in partnership with medical centers to expand our capacity to reach to those of—in the community who need our services the most. In Brooklyn and Queens, the boroughs with the highest Arabic and South Asian immigrant population we are able to deliver workshops and products ranging from health insurance options through Urban—Urban Health (sic) Health and Hospitals, Hospitals to the dangerous prescription drugs abused and presentation in the schools and colleges. Everyday we are working to educate our communities and their right to access to healthcare

and helping them to find the—the health—access to health they need. I do want to finish it up. I don't want to take too much time, but I want to thank Corey Johnson for being a champion for our coalition for helping us and giving us the funds that we are requesting more. As a Muslim Arab-American community is in needs. There is a big field in our communities that we need to reach out to—to educate them—to educate them on their right to access to healthcare. I just want to show you something. I would love to give you where the money went to help our clients to carry their documents when they come to enroll in health insurance, and they could—the know that access health money works and our contact information is right there to reach out to—to us right away. I just want to thank you for giving us a chance to help our communities?

CHAIRPERSON JOHNSON: Thank you. You get the gold star. [laughter] You're the first one to go, and you were under your time.

MAHA ALTIA: But I only have to—

CHAIRPERSON JOHNSON: You're the example. Let's keep good.

Thank you, alright. I'm going to try to top that. [laughter]

MAHA ALTIA: Corey Johnson is right there. [bell]

ALEXIS POSEY: My name is Alexis Posey, and I'm the Senior Policy Analyst at FPWA. Curb the Way would like to thank Chairman Johnson and members of the New York City Council Committee on Health for the opportunity to testify on behalf of the Access Health NYC initiative today. Also, FPWA would like the New York City Council for the inclusion of the Access Health NYC Initiative in both the FY16 and FY17. Since the time the initiative has been great successful in connecting New York City residents to education and resources needed to attain health insurance and quality healthcare. As FPWA envisions being a driving force of building the city's equal opportunity, we believe New York City must reduce health disparities by ensuring that all New Yorker have healthcare access and coverage, and their targeted programs and policies are in place to address health crises and has disproportionately impacted low-income and disadvantaged communities such as the HIV-AIDS epidemic. It is for this reason

FPWA recommends the City Council provide an enhancement of Access Health NYC Initiative to $5 million in FY18 Budget. [laughter] Since receiving the initial funding from the New York City Council in Fiscal Year 2015, Access Health NYC has made significant achievements in the effort to close the health access gap. In Year 1 alone, Access Health conducted 126 trainings and workshops and were held across the city, and nearly 6,000 individuals have been reached. In this second year, over 10,000 individuals have been reached through trainings, workshops, community events and individual outreach. Funding was allocated to an addition 14 organizations that specifically work with the formerly incarcerated, homeless, people living with HIV and AIDS and deaf and disabled population. Additional support to CBOs addressing the potential changes to healthcare and the impacts on the marginalized communities has also been given since January. In 2017, the Access Health NYC Initiative provided resources to organizations across New York City in response to the concerns of uncertainty of thousands of residents in regards to healthcare. An enhancement to $5 million in the FY18 Budget will

allow multiple CBOs from every Council District to participate in the Access Health NYC Initiative and carry no this critically important. Thank you.

CHAIRPERSON JOHNSON: You're awesome. Thanks.

ALEXIS POSEY: Great.

CHAIRPERSON JOHNSON: Go ahead, Claudia.

CLAUDIA CALHOUN: Good afternoon [coughs]. My name is Claudia Calhoun. I'm the Health Advocacy Director at the New York Immigration Coalition, and I'm here to talk about all the good things that New York City Council funded Access Health NYC Initiative has done. Alexis covered a lot of that material. So I will kind of jump to the—the stuff that I think I can offer that's unique, but we definitely want to take this opportunity to thank Council Member—Council Member Johnson for all his work on this initiative. The NYC is involved in—has been deeply involved in the advocacy for this work, and we also have the role of trainer for the organizations that get funding from it, and—and they're here today as well. So, from this experience we've had direct and know of the value that these resources have meant in real time. We bring people

together. We hear about the work that they're doing. We hear about what it means to their communities. I think, you know, we've talked a lot about today how immigrants are entering an ever deepening period of stress and vulnerability related to the federal administration. We do hear reports of plummeting patient censuses that they—that healthcare providers attribute to fear among immigrants using health services or coverage, and there also have been false reports that are flowing across the city about the presence of ICE in Health and Hospitals, which—which did not turn out to be substantiated, but did have an impact on people seeking care, and it's very scary for communities to think about going to especially to a public hospital part of the—the government. We dodged this massive bullet on Friday with the House of Representatives' proposal going down in flames, but we know that there will continue to be federal threats to—to—to healthcare financing that will affect New York City greatly, and in the context it's just essential. Access Health is sort of read to go. I t's the perfect solution to make sure that as changes, any changes do come about, there's—there's a cadre of CBOs that can get the word out to everyone

about what correct information about the changes, and where they can continue to go to get healthcare safely and securely. Alexis mentioned some of the statistics. More than 10,000 individuals have been reached. Organizations have since the beginning of the initiative they've provided more than 250 workshops trainings and community presentations, and they've referred more than 2,000 individuals through navigators, healthcare providers enrollment offices for food stamps and other social services, and I would just highlight that those numbers are not complete. There is no sort of mandatory reporting system really for the—for the initiative that—that we are able to take advantage of, and so we have collected our own data voluntarily, and so that's just really 13—13 of the total organizations. And so the—I think if you had an—an opportunity to look at the full—the full impact, it would be much higher. So we are requesting a $5 million commitment to Access Health NYC and the other thing I attached as part of my testimony is a—it is a map of Council Districts, and insurance rates, and it is pre-ACA, but I think that we know that those—those districts still remain affected and so there's a list of the

different districts and some of the Council Members whose districts could really benefit if there were an enhancement. Thank you.

CHAIRPERSON JOHNSON: Thank you.

SUZANNE ROBINSON-DAVIS: Good afternoon. My name is Suzanne Robinson-Davis and I'm from Bedford-Stuyvesant Family Health Center, one of the grantees on the Access Health Initiative. Bedford-Stuyvesant Family Health Center is an FQHC, and as we all know from the previous panel that FQHC serves person regardless of their ability to pay and regardless of their immigration status. Our center is a safety net facility that targets the—targets the neediest within our primary service area. We know from our demographic socio-economic disease prevalence data and other vital statistics that pockets of our target service area particularly color and communities were poor Medicaid eligible African-Americans and Hispanic communities or the vast majority have among New York City's highest prevalence of chronic illnesses. After one year and four months since implementing the Access Health Initiative we have learned that the community is thirsty to be engaged and years to discuss health—

sorry—to discuss health effects—how health affects them and their community. This should come as no surprise as participatory action results in a voluminous response from our communities. People gravitate to spaces in which they can freely share ideas, thoughts and experiences. Access Health funding creates these spaces, and presently is the only funding source we have that is not limited by a diseased area or health condition, but addresses the broad spectrum of health, health engagement and insurance coverage. So I want to quickly share two stories with you. I love to share stories, and the first one we had a workshop and one of the participants indicated to—to us that after two years she was really interested in obtaining insurance. We actually showed the Access Health video, and that really triggered her into action. We were able to connect her to insurance coverage immediately after the workshop and impressively she had a medical visit two days later. So we're very proud of that. Another story that is actually very close to me is this LGBT community member expressed dissatisfaction with how insensitive—insensitively he was treated by his provider, and how the provider would not touch

him without putting on two pairs of gloves. He felt demeaned, discriminated and rejected. He disclosed to our health educator, a position funded by the initiative, that he was actually HIV positive. We referred him our LGBT COMPASS provider, and after his appointment he called the office to say thank you. We had a wonderful medical visit. He loved his provider [bell] who showed him friendly and non-judgmental service, and who actually wore no gloves. So we're really happy about the ability to be able to engage with our community and link them into competent and quality healthcare.

CHAIRPERSON JOHNSON: Thank you all very much. Thank you.

SUZANNE ROBINSON-DAVIS: Thank you.

CHAIRPERSON JOHNSON: So we're going to go next with Christian Zang, Carlos Rosario, Ronnie Marx, Annette Gardino, and Hiawatha Collins, and the after that we're going to do Chris Norwood and Kendra Oke. [background comments, pause] Your next.

SERGEANT-AT-ARMS: [off mic] The people who are next. [door bangs]

RONNIE MARX: Am I starting?

CHAIRPERSON JOHNSON: Go ahead.

RONNIE MARX: Okay. My name is Ronnie Marx and I'm here today as a patient who was cured of Hepatitis C two years ago. I'm also facilitator of support groups for 17 years at leading New York City hospitals and the Founder and Executive Director of the Hepatitis C Mentoring Supporting Group. So in addition to being a patient, I have experienced working with those patients and providers. At HCMSG we provide education and supportive services for people living with Hepatitis C, and HIV co-infection throughout New York City. Educational groups and supportive patient mentoring services has been shown to be important elements of successful and cost-effective medical care for patients with Hepatitis C and other chronic health conditions. These services improve the quality of life as well as medical outcomes for patients. The trainings we provide for healthcare providers help them to have a better understanding of how to work with all patients including high risk populations such as former and current drug users, the LGBTQ community, youth and women of child bearing age dealing with Hepatitis C and those co-infected. Approximately 2.4 of New York City residents 20 years and older have Hepatitis C

and one 1.2% have Hepatitis B. Many are walking around unaware and the incidents of liver cancer remains high amongst New York City residents. This is why it's critical to the City Council to again support and this year to expand the City Council Viral Hepatitis Initiative. We need increased access to Hepatitis C testing, treatment, syringe exchange services and the ability of New Yorkers to fill prescription at the pharmacy of their choice. As a patient who has been cured from Hepatitis C and one who works with patients, I can tell you first hand what an impact this virus has on someone. It affects the whole body not just the liver. Being cured had been the key to having people turn their lives around. There is such power in having supportive services and patient navigators. It is essential for patients to work with people who understand what they are going through, and can help them get through the process and make it easier for patients to adhere to treatment. In many cases it has helped to reduce the feeling of stigma associated with having Hepatitis. It is important to address both the psychological impact as well as physiological impact. I have collaborated on the New York State Hepatitis C

Elimination Initiative, and I would like to see us all work to make this the model for the entire country with New York as the first city and state to eliminate Hepatitis C. I ask that Mayor include Viral Hepatitis in his Executive Budget as well. Please help make sure that all New York City residents have access to Hepatitis C testing, treatment and care regardless of race, gender, and economic status. Thank you.

CHRISTINA ZANG: Alright, hi. My name is Christina Zang. I am a Hepatology Physician Assistant at NYU Langone. I'm also part of the Asian Liver Health Program at NY Langone. I'm here to—for the testimony for the Viral Hepatitis Initiative budget. I want to point out that 100,000 NYC residents are positive for Hep B and 146,500 NYC residents age 20 and older are positive with Hep C. One out of 12 Asian-Americans are positive for Hep B and 2 out of three are not aware of their Hepatitis B disease. I can prove this by—by telling you about my free Hepatitis B and C screening events that I was part of last year. So, we at NYU collaborated with CAMS, the Chinese Medical Society and VNS, the Visiting Nurse Services to organize a free

educational Hepatitis B and C screening event last year. So before the screening events we did an educational seminar where I did the Hep B a seminar in Chinese. Thirty-five people came out to participate in the educational seminar and 26 participated in the blood drawing screening. Out of the 26, 3 were positive for Hep B and 2 out of the 3 were not aware of their disease. The prevalence of Hep B among Asian-Americans is clear. In fact, the CDC published that even though the Asian-American and the Pacific Islanders only make up 5% of the population the U.S., they accounted for 50% of the Hepatitis C cases in the U.S. I also wanted to point out that Hepatitis B and C are silent killers. Usually when these patients they don't feel any like pain or any other symptoms or discomfort. When they do feel it, it's usually in a stage when—when it's like too late. The lack of knowledge and awareness of the severity of Hep B and Hep C need to be addressed, and I hope you can continue to support the Viral Hepatitis Initiative. [pause]

ANNETTE GARDINO: Hello. My name is Annette Gardino. I'm the HCV, HIV Project Co-Director for TAG, Treatment Action Group, and I'm

here to speak in support for expanded funding for the City Council's Viral Hepatitis Initiative. At the recent New York State Viral Hepatitis Elimination Summit, elected official, New York State DOH, New York City DOHMH, and community leaders committed to elimination of Hepatitis B and C as public health threats in New York State presenting comprehensive recommendations to achieve these goals. Yesterday, the National Academy of Sciences released their national strategy for elimination of Hep B and C Phase II Report, which includes detailed expert recommendations to achieve these goals on a national level. These efforts follow the World Health Organization's call for global elimination of Viral Hepatitis by 2030. Community providers, researches of government are in consensus. Elimination of Viral Hepatitis is feasible. We have evidence-based recommends to achieve it and we have resources to fill in the gaps and to take concrete measurable steps. New York City and New York State are national leaders in the response to the Viral Hepatitis. In order to continue our leadership and to provide a model for other states faced with this public health challenge, New York City must continue and expand our

innovative programs. Specifically, thanks to City Council funding in 2016, Check Hep B Patient—Check Hep B Patient Navigation Program linked hundreds of immigrant New Yorkers who speak over a dozen languages to care in 70 at 70 community sites—seven community sites. The Check Hep C Patient Navigation Program linked over 700 hard to reach new Yorkers to care with 271 completing treatment. Hep—the Hep C Peer Navigation Program provided prevention services at 16 new exchange programs serving both the baby boomer population, which includes approximately 70% of those with chronic Hepatitis C infection nationwide and younger people who inject drugs who are at high risk for infection. The Injection Drug Users Health Alliance, which includes the Syringe Exchange Programs in the city reports that 91% of people who participated in their harm reduction services have been tested for Hep C, a remarkable number considering that the overall, 50% of New Yorkers are unaware of their status. We call on the City Council to expand the capacity of the Hep C Navigation Program and the Check B Patient Navi—Check Hep C Patient Navigators. We ask you to expand the capacity of Check B program to include one more

health center and provide for annual cancer screenings, and to also fund the Patient Navigator Services at Montefiore Medical Center in the Bronx, which were previously funded under Project Inspire and to expand the pool of qualified providers by continuing your funding to the Empire Liver Foundation's Clinical Mentoring Program and the Hepatitis C Mentoring Support Group. The entire nation is watching New York City's response to Viral Hepatitis. Let's show them that we're building on success and moving towards elimination. Thank you for your time and for the opportunity to testify before the committee.

CARLO ROSARIO: Everyone she said. Hi everyone. My name is Carlos. I am a wellness advocate with Vocal New York. I'm here to read a testimony from one of our members Mr. Kenneth Merrick. Dear New York City Council Health Committee. My name is Kenneth Merrick and I am submitting this testimony to stress the importance of Hepatitis C related services in New York City. I was screened for Hepatitis C in the summer of 2016 at Vocal New York a Brooklyn based Syringe Exchange Program, and grassroots organization. It was then

that I learned I had been living with Hepatitis C. Immediately following my positive test results I was introduced to a Hep C Peer Navigator who accompanied me to and from my doctor appointments, which were scheduled for me the very same day I was tested for Hep C. In addition to accompanying me to my appointments, my peer navigator gave me information regarding Hep C and how best to prevent its transmission. More importantly my peer navigator checked in on my progress on a regular basis. As a person directly impacted by Hep C, I began advocating for others like me by practicing in numerous community protests. I'm proud to say that I was one of the many people who joined the Drug Utilization Review Board protest. Fortunately, the Board lifted New York State Medicaid restriction to treatments that were unfairly based on liver fibrosis scoring. The Board's decision came shortly after the New York Attorney General's Office was able to get several private insurance restrictions lifted. This allowed me to finally access the cure I had been consistently denied. However, protests and lawsuits should not be a perquisite to receiving treatment for a virus that kills more people than any other infectious disease

nationwide including the combined deaths of HIV, Tuberulosis and 58 other infectious diseases. As a result of my positive experiences with Hep C peer navigators who even today continue to periodically check in on me, I feel inspired to become a peer navigator myself. I would like to play a role in the wellbeing of people like myself who have been cured of Hepatitis C virus, and are living with—and are now living a healthier life free of the epidemic. Experiences like mine are instrumental to eliminating Hepatitis C. We have a cure, but without testing and the critical work of peer navigators many people will continue to be undiagnosed and untreated. Please consider my success story as one of the many reasons to continue funding these crucial programs in our city. Thank you.

HIAWATHA COLLINS: [coughs] My name is Hiawatha Collins, and presenting on behalf of the Harm Reduction Coalition and the Peer Network of New York. I am also a Vocal Board Member. In support of the proposed budget increase for the New York City Viral Hepatitis Initiative, I would be focused on the comments on the Hepatitis C Peer Network Program—excuse me—Peer Navigation Program because I am

responsible for the coordination of the program and helping to support the Peer Navigators. [coughs] The Hep C Peer Navigators Program provides funding—funding to employ two peer navigators at all of the 15 New York City Syringe Exchange Programs as well as funding the Harm Reduction Coalition to provide training, coordination, and technical assistance. The Peer Network of New York meet once a month and it assists in the personal and professional development of the peers from across the city. I'm not going to talk about the statistics because you're going to hear a lot about that from others. It is essential that the New York City continues funding the initiative, and I urge you to increase the funding for the Peer Navigation Program from $2,000--$216,000 to $330,830 as proposed. Every dollar for the—for New York City also triggers a fifty cent match the State. So the funding has a larger impact. The proposed increase in funds would expand the available hours of services provided by Hep C Peer Navigators at all the Syringe Programs throughout the city. The program outcomes shows that the City Council's funding is having a strong impact in some of the community's hardest hit by Hepatitis C. But the

program's capacity and geo—geo—geological coverage must be expanded in order to address the dramatic gaps in the city's Hepatitis C treatment cascade. The Harm Reduction Coalition and the Peer Network of New York believe that it is crucial that the New York Viral Hepatitis Initiative be expanded this year. We hear lot from the peers on the ground about the great work that they are doing and how they feel about doing their work. They also refer to—they also are referring some of the most stigmatized and mod—modularized individuals in the community and to treatment. They do this from a non-judgement and unbiased manner. The peers have lived the experience so they can related to the individuals they serve. They save the community on unnecessary hospital and ER visits by providing resources and many other needed services With more funding more lives could be saved. The peers on the ground go into communities and reach those that were thought by some to be unreachable. Every life counts and the peers and the programs have a proven record of success, and with more funding they could continue to save the lives of New Yorkers. With more funding peers could give more hours to assist with the follow-up of the

clients and there could be more peers hired on the sites, and they could meet more better to cover more shifts and times not covered. What we want to do is to continue to have the peers meet more funding so that they can get adequate—adequately paid. Thank you very much.

CHAIRPERSON JOHNSON: Thank you all very much. Okay, next up, Chris Norwood and Kendra Oke. [pause]

CHRIS NORWOOD: It's on. It's got a red light. Okay. I'm Chris Norwood, Executive Director of Health People and I'm speaking for the Diabetes Epidemic Must Stop Prevention Coalition. New York City has 1.3 million pre-diabetics. Most will develop diabetes if nothing is done. It's quite a shock that in our city nothing is being done. The City Department of Health does not put any funding into the best proven prevention, that is the DPP, the National Diabetes Prevention Program, a multi session course with the goal of participants' losing 5 to 7% of their body weight, and starting to exercise, even walk regularly. Most participants do this and it unquestionably after mammoth research reduced their diabetes risk by a staggering 60%. That also means

that all the complications of diabetes complications so dire that it is now clear diabetes is itself the most preventable cause of Alzheimer's Disease. We are requesting the City Council to please, please start its own diabetes prevention initiative, and finally bring the best proven prevention available to start ending the staggering diabetes epidemic in our city. It is incomprehensible that the city stopped even in October the handful of $12,000 grants, which it had carved out of its CDC money for the DPP, meaning it does nothing now, and it stopped that even before there was any question of the kind of situation we are facing today. The diabetes epidemic must stop. Prevention Coalition with bring this diabetes prevention to high need area all over the city. For example in Bronx, Sobro will teach the DPP and education. In Brooklyn, the Arthur Ash Institute will focus on high risk African-American and Afro Caribbean men in its Barber Shop Talk Program, and New Creation Community Health Empowerment will activate its many faith based members. The Caribbean Women's Health Association will fight the alarming increase in maternal deaths clearly associated with obesity and diabetes by providing women's classes in

Brooklyn and Staten Island. The South Asian Council for Social Services in Queens will focus on immigrant populations who have very high diabetes rates, and in Manhattan the Alliance for positive change will bring the DPP to people with HIV-AIDs, a group that has the two-fold higher diabetes rate, and the Independent Living Center will bring this prevention for the first time to people with impaired vision. Basically, there is no other way except for the City Council to intervene with its own diabetes prevention initiative and stop an epidemic, which is not just killing, it is blinding them, sending them into dialysis by the hundreds, causing foot amputations and raising the risk of Alzheimer's by 40%. We have here an outline of the Citywide Initiative, which I am working with your schedule Mr. Chairman to go over with you in detail. Thank you.

CHAIRPERSON JOHNSON: Thank you, Chris.

KENDRA OKE: [off mic] Hi. I'm Kendra Okie. [on mic] Hi, I'm Kendra Okie. If you guys remind of a story, I'll try to do two minutes okay. So since Chris gave you the numbers on what we need, I just want to let you know my name is Kendra Oke. I am the CEO of Crossover Television Live. I broadcast

every Thursday night at Lehman College. I met Chris by way of coming up. She taught lead segment on my program, and everybody called me the following day about not losing limbs and how to protect your feet. That's something—I've been a diabetic for over 20 years and doctor has never told me how to protect my feet, has never looked at my feet during an exam. My dad died of diabetes. He was on dialysis at 47. My mom passed away on dialysis at 64. I'm 47 and my son is autistic and he is 11, and I'm just thinking I'd like to be here 25 more years just for him. But thanks to Chris Norwood and her program I lost 35 pounds. My A1C went from 8 to 6.5, and it's just a blessing to know that a program like this it—it just gets us out of the house. I was lost. I was hopeless, and I just thought I was going to be next just like my mom and my dad. Unfortunately, my vision is very bad. It's almost gone, and I just want to say that it may be too late for me for my vision. I'm 25—almost 25 years in the game of this, but what about the young people that—that they can have a life? Because I feel like as a chronic diabetic everything is lost for me. So I don't want that to be for the next generation to come. When I

heard—when Chris Norwood told me that there was no money allotted I was shocked, and I just thought I should go to the public and speak to my audience, my viewing audience and talk to them about better taking care of themselves, about how to be healthier and how to live longer with diabetes and not have all the chronic, you know, issues that I have with diabetes now. So we have a lot of work to do, and I really hope that you could take into consideration that, you know, we definitely want to say that the diabetes epidemic must stop. I'll say that on TV everyday, but we have to make some changes, and, you know, she's a force to be reckoned with. You can't tell her no. So I hope you guys think about that. I just hope—you cannot tell Chris Norwood no. She's funded the AIDS program and so many other programs in the Bronx that, you know, she's awesome. So we have to bring some support, and there's not way that she should be doing this alone, you know, doing so much alone. I'm a diabetes peer coach leader. She trained me through the FANTA Curriculum, and now I taught my first class, graduated that. I'm just excited and we just have to keep working together as a community to better our community. Thank you.

CHAIRPERSON JOHNSON: Thank you, thank you very much for telling your story, and thank you for being here, Chris. Thanks for your patience today. I know you guys have been here for a long time. So thank you very much. Okay, up next we have Mitchell Colton, Mitchell Cohen, Katherine Swan, William Sucray, Esther Koslow and Adelia Honeywood Harrison. [background comments, pause] Go ahead. Sit on down. Let's get going. Come on. [pause] Okay, you may begin. Go ahead sir. Alright, go ahead.

MITCHELL COHEN: My name is Mitchell Cohen from the No Spray Coalition. This is against spraying of pesticides in New York City after the Department of Health helped to facilitate and run for the past 18 years. I just wanted to recognize that today is also the anniversary of the meltdown at Three-Mile Island, and I think—so I'm glad to see that Indian Point is finally going to be closed some time in the near future I hope, and will save health risks and people's health that way, but I think it's important to remember our history. Part of that history has to do with the No Spray Coalition filed the lawsuit and won eventually against New York City,

and we filed it in the year 2000. We won in 2007 against the spraying of toxic pesticides from airplanes and spray trucks throughout the city against the West Nile Virus to kill mosquitoes. And in that lawsuit, the parties stipulated, the city stipulated to certain admissions that included that recognition that the pesticides may remain in the environment beyond their intended purpose. They cause adverse health effects. They kill mosquitoes' natural predators like dragon flies, bats, frogs and birds and they increase mosquitoes resistance to the spray, and they're not presently approved for direct application over the waterways. Yet, what's happened over the years is it's as if those admissions never existed, as if that settlement never existed. As if Local Law 37 doesn't exist that the City Council passed in 2005, which sought to limit the amount of pesticides spread in New York City by the Department of Health and other agencies. So what I'm testifying about today is I want to know where is the accountability by the Department of Health when it submits their budget that's actually increase over two years go. They sort of fudged the numbers and said well, last—this year's budget has declined by

10% or $#10,000, but compare it to the year before and the years before last, which is exceptional because of the Zika, and it's actually an increase over that. And so I'm worried about the intentions of the city, the Department of Health and the oversight of the City Council on the Department of Health. The Department of Health grants itself a waiver. Get that again. It grants itself a waiver to declare the emergency so that it itself that agency can spray. Not the City Council declares or— or grants a waiver. Not some other agency. It's the Commissioner of the Department of Health, and this is a problem. Where's the accountability? At least have some other people looking at all of this before they go out and poison the people of New York. People are really made sick, animals are made sick, pets are made sick, the environment is made sick. If you want to save money for the hospitals and healthcare all around the city, stop making people sick, and then we'll save some money as well as improve the quality of life in the City.

CHAIRPERSON JOHNSON: Thank you.

KATHERINE SWAN: Hi. My name is Katherine Swan. I'm also with the No Spray

Coalition. I am also a writer and an animal advocate. The West Nile Virus pesticide spraying is categorized in the Department of Health Budget under environmental health, yet, no comprehensive assessment of the spray program on environmental health on environmental health has ever been done since the spraying dramatically began by plane and helicopter 18 years ago under Mayor Giuliani. And while the effectiveness of the spraying is questionable as far as whether its effectiveness on mosquitoes, killing mosquitoes, what we do know is that these substances kill natural predators of the mosquito, the lady bugs, the bees, the dragon flies as well as the birds, insects. They do harm human health, they do harm our animals and pets and our entire ecosystem. It's never been proven that this is an effective program or money well spent. It's basically stayed the same with a few modifications based on meetings that the No Spray Coalition had with the Department of Health, the EPA, OSHA, and the DEC, but that was ten years ago. There's never been an emphasis on education, alternatives or true acknowledgement by the city that these pesticides do actually harm human health and the ecosystem. So it

is time for a significant review. The issue I wanted to address was the—is the ACC, which is also listed under Environmental Health as animal control, but the focus really needs to be on animal care. The care of the animals of our city should be given serious consideration and its own category in the budget. The building of the new shelters is great, but the budget does not address the animals that are going through the system now. It is has been clear for years that they ACC budget is not sufficient to adequately care for city's cats, dogs and other animals, and keeping this amount basically static continues to do them a huge disservice. It should be greatly increased now before more animals die. The—the animals of our city deserve so much better. They are our responsibility, all of us. There should be significant money given to an education campaign on that alone. So many animals are surrendered and killed just because of space, not being given enough time to find homes. They get—they come in healthy, they get sick there. They're terrified being there, and why shouldn't they be. I mean the—you know, they—they can feel the situation that's going on there, and they're—and they're terror becomes a death

sentence. This Administration can show a true commitment to the animals of New York City by upping the money to their care immediately before more die. Thank you.

ESTHER KOSLOW: Good afternoon. I'm Esther Koslow, Chairperson of Shelter Reform Action Committee. This time a year ago, Animal Care Centers of New York asked the Council for $15 million in funding under its services contract with the Department of Health. Unfortunately, ACC came up $2.2 million short hobbling its efforts to keep its animals safe from disease and healthy enough to be adopted rather than there being transferred sick to rescue groups. The Avian Flu Crisis, which had the potential to morph into a great public health crisis highlights the problems faced by and underfunded AC&C. The DOH shouldn't play chicken with the AC&C's budget. By that I mean the DOH shouldn't be sitting there hoping that private charities will step in and make up any budget shortfall. That's now—not how the AC&C should be funded. We thank Mayor de Blasio for promising major capital improvements for the AC&C. Promised innovations to the existing shelters and the creation of new shelter will go a long way to keeping

animals healthy. But the fact is that those capital projects are years and years away as you, Chairman Johnson, noted. What's the AC&C to do in the interim without proper annual funding to operate? That's why Shelter Reform urges that the AC&C funding for Fiscal Year 2018 be increased to at least $15 million. I know that the Finance Vision Report prepared for this hearing states that animal control funding will be $15 million. That phrase "animal control funding," as Chairman Johnson noted, is misleading. It is not the same thing as AC&C funding. The DOH proposes to pay far less than $15 million to the AC&C. The Finance Report also offers as a performance indicator the DOH's efforts at dog licensing. Using that same metric, the DOH gets a failing grade. Dog licensing compliance continues its downward plunge. For example, in 2010 the DOH reported that 100,000 dogs had been licensed, which the DOH calculated to be a 20% compliance rate. Now, only 86,000 dogs are licensed. I submit that dog licensing is an indicator or the DOH's lack of commitment to animal health, which can directly affect human health. A licensed dog is a rabies vaccinated dog. The DOH fails when potentially hundreds of thousands of dogs

go unvaccinated, and yes you should also look into the DOH's enforcement of the Pet Shop Law and how much money it's taken in taxpayer dollars not to enforce it. [bell] And I hope we'll have a special hearing about this soon. Thank you.

BILL SHAKLEE: Good after—good afternoon, and thank you, Chairman Johnson for the opportunity to comment on the budgetary funding for Animal Care Centers of New York. I'm Bill Shaklee (sp?), the Legislative Director of the League of Humane Voters of New York. We attended the recent AC&C Board Meeting and were most disappointed to learn that the DOH announced a new adoption center in Manhattan, and the new HVA system for Brooklyn are still three years away after being announced in January of 2015. We applaud the Mayor and the Council for the funding of planning and development of new shelters for the Bronx and Queens, but we're more than five years away from the opening of both again per the DOH. We feel strongly that AC&C be fully funded in the proposed budget. The AC&C team has made enormous progress under the leadership of Ms. Weinstock its Executive Director. However, with antiquated facilities and improvements years away, anything less than full

funding is a disservice to the animals and people of New York City. Thank you.

ADELIA HONEYWOOD: Hello. My name is Adelia Honeywood. I am a cat rescuer with Brooklyn Cat Café. I live in Council Member Eugene's district where over several years I've spent a lot of my spare time and my own dime doing trap neuter release with feral cats in the neighborhood. I echo what has been said here about the need to increase funding both in the contract and the capital plan for ACC because the function or dysfunction of our shelter system is not just an animal welfare issue. It is a human welfare issue that affects the emotional wellbeing of New Yorkers and their quality of life on the streets of their neighborhoods especially for more vulnerable populations. As they have said, ACC has worked very hard and made great strides, but they operate on a meager budget and antiquated facilities, and the reality is that healthy animals are still killed for lack of space or they contract life threatening illnesses after entering the shelter. What this mean is that New Yorkers don't have a shelter system they can trust in times of crisis. Rescuers get so many pleas from people in dire situations. Maybe they've

been evicted, they've lost their job, they have a serious illness, and they can't care for their pet any more, and the last thing they want to do is send their beloved companion to its possible death in the shelter. And rescuers can't take them all, and people have said to me well, I'd rather my cat chance it on the streets, and let's say that cat isn't spayed or neutered because it's really expensive to spay or neuter, and the low-cost spay/neuter services are often very hard to access. So that cat makes hundreds more, and you have streets full of suffering cats, and it's a public nuisance to some and daily heartbreak to others or maybe both. And if someone six months earlier could have taken their cat to ACC with confidence that it would come out alive, there would probably be a lot fewer cats on the streets. When I moved to my neighborhood in 2007, there were cats everywhere. You saw emaciated cats in subzero temperatures pawing the garbage. You saw sick kittens dying on the streets or with eye infections that have turned their eyeballs to mush, and it's a heartbreaking thing to walk through everyday, and that was Ditmas Park, which is a pretty affluent neighborhood. And in less affluent neighborhoods,

the situation is a thousand times worse, and there might not be people who can take on TNR on their own. So in order to truly help people and their pets as they have said, ACC needs the full funding. They need the new shelters and the renovations much faster than on a ten-year timeline, and we just urge the city to step it up. Thank you.

CHAIRPERSON JOHNSON: I agree with everything you all have said. I'm pushing. I keep pushing. I deserve more money, they need the money. The shelters should be done already by now actually. Should have been done a long time ago. So I'm with in this fight and we'll keep pushing. Thank you very much.

ADELIA HONEYWOOD: Thank you.

CHAIRPERSON JOHNSON: Okay. [coughs] Next ups is Laura Redman, Joel Cupperman, Fitz Reed, and Alex Ring.

MALE SPEAKER: [off mic]

CHAIRPERSON JOHNSON: Okay. Is Laura Redman here? That's you. Joel?

MALE SPEAKER: Do you call him? (sic)

CHAIRPERSON JOHNSON: Excuse me?

MALE SPEAKER: Do you call him? (sic)

CHAIRPERSON JOHNSON: No, but soon. No, I didn't call Phyllis White. Laura Redman. Are you Alex?

MALE SPEAKER: [off mic]

CHAIRPERSON JOHNSON: Okay, so Fitz Reed is no longer here, and Joel Cupperman? He left. Okay, so he left. So, let me call up Phyllis White you can go up, yes [background comments] and Wayne Clark. Is Wayne Clark here? No Wayne Clark. Amanda Lug? Is Amanda Lug here?

AMANDA LUG: [off mic] Yes.

CHAIRPERSON JOHNSON: Come on up. Okay, you may begin.

LAURA REDMAN: Hi, good afternoon. My name is Laura Redman. I'm the Director of Health Justice Program at the New York Lawyers for the Public Interest, and I thank you for hearing our testimony today. We are legal services organization that uses a community lawyering model and focuses on health, disability and environmental justice. Most of the work of my program focuses on the intersection of immigrant and health justice. I just want to talk very quickly today about how NYLPI is honored to be part of this City Council's Immigrant Health

Initiative, and we thank you for the support. NYLPI and our partners received over $500,000 in funding last year, and this support has allowed us to expand our work, educating immigrant New Yorkers with serious health conditions. We help connect to state funded Medicaid. We provide them with immigration representation and then also advocacy navigating the healthcare system and particularly for a transplant. Through this funding we are also able to train legal services providers, community based organizations, and healthcare providers. We're able to provide a direct service to individuals and community as well as train those who—who they are working with. In the current environment, which speaking to our clients has reached the level of a crisis, many of our clients are in more vulnerable space with regard to immigration status, which has a direct impact on their health. I'm sure you're all aware people hear rumors and are fearful of seeking healthcare and even leaving their homes. We've had clients asked if I go to dialysis will be picked up by ICE? In response our initiative has incorporated And Know Your Rights and Train the Trainer program focused on general law enforcement and healthcare rights for patients,

providers and immigration advocates to be carried out with our community health partners and entrusted spaces where people receive healthcare. We want to counter those rumors with the power of knowledge. It also includes safety planning and legal resources, and we're developing a cutting edge defensive program to prepare our various client for unfortunate eventualities such as being detained, which is becoming more real for people. Moving into detention, our Immigrant Health Initiative funding has also supported NYLPI's work seeking to improve access to healthcare and immigration detention facilities. We proved individual and systemic advocacy to improve healthcare and we've helped many people get out of detention based on their healthcare needs. We recently released a report spotlighting these issues, and we intend to use that report as a way of inspiring further advocacy and commitment to immigrant legal services. We thank the Council again for this tremendous assistance, and we ask that the funding continue. We also ask for an enhancement for $100,000 for NYLPI to expand our successful Immigrant Health Program, and in response to the current moment in time. Lastly, I just want to say in terms of

general healthcare and health coverage we encourage the city and the City Council to strategize and designate funds to address any gaps that may be or will be created based upon a loss of federal and/or state funds or whatever is coming down the pipe. We implore on you all to do whatever possible to keep the status quo and to continue to push for coverage for all New Yorkers. Thank you.

CHAIRPERSON JOHNSON: Thank you. [bell]

ALEX LEON: Good evening. My name is Alex Leon. I'm a shop—[pause]. Push the button? There you go. I'm Alex Leon. I'm actually a shop steward for the Medical Legal Investigators, and I'm here representing them on behalf of the title at the OCME. I know you guys spoke a bit earlier in regards to that, and I just want to fill you in as to what's going on. Currently I am, you know, already we're composed of Physician Assistants and nurse practitioners, and it was a role that was started in about 1989 by Dr. Hirsch, and which he had physicians kind of going out to scenes, and he felt that he wanted a more dedicated person who had medical knowledge to do that dedicated distinctly, and have the medical examiners stay in and do the actual

autopsies and do everything else. So at that point in time Pas and Nurse Practitioners have kind of taken over, and we've—at some point about a decade ago we've grown to about 50 some odd medical legal investigators. Over time and in the past decade we've dwindled down to now actually 23 active investigators covering the five boroughs of New York City. So that's—that's—I don't know, if you think about it, that's 23 people covering New York City five boroughs. It starts dwindling around down to very few people covering per shift over a period of time. As of last night there was just three covering five boroughs, and you can imagine. What has happened now is there's an increase in response time if you look at the data they've provided, and just also want to let you know that there's just a huge staffing and retention problem that's going on, and-- I mean we've been working with actually Dina Maniotis about this issue. We've brought this. So I was actually here three years ago talking about the developing problem that was going on. So, I mean with the increase in opioid dependence, deaths, overdoses, heroin, and the—and the areas in the Bronx and Staten Island, which requires MLIs to go out to

cover, and there's no offices there exactly. So the MLIs actually have to drive out there. It takes time, and because of the limited staffing there's delays, and the last thing we want is to have delays of the public waiting for us to come out and actually, you know, handle the situation and take care of the deceased. So all we're-all we're asking is just that, you know, you're aware of the issues and the problems that's going on in regards to staffing and the retention problems that's going on and you guys touched upon it briefly at the point of time earlier in the day. So, I'm just here to fill in any questions you may have briefly if you have any.

CHAIRPERSON JOHNSON: Well, I'm glad you came. I'm glad you stayed. You should get the contact information for the committee counsel, David Seitzer, and if there are issues that come [bell] related to filling the positions, retention issues, things that you think that we should be asking about or looking into we're happy to have that type of relationship with you--

ALEX LEON: [interposing] Absolutely.

CHAIRPERSON JOHNSON: --moving forward.

ALEX LEON: Thank you for your time.

CHAIRPERSON JOHNSON: Thank you. Mr. Zweig.

PHIL ZWEIG: Hi. My name Phil Zweig. I'm Executive Director of a non-profit pro bono group called Physicians Against Drug Shortages. We're a patron advocacy group. Most of our members are anesthesiologists and critical care specialists. We were founded in 2012 in order to address the critical shortages of generic drugs that were in such crisis and still are. Our members could no longer get the drugs. They need to put their patients to sleep. If they could, the prices were sky—were and still are skyrocketing. I'm a former. I'm not a physician. I'm a former reporter for the Wall Street Journal, the Bloomberg News and Editor of Business Week. The real root—let me just say that when I heard Mr. Brezenoff refer to $63 million in savings this pocket change. I'm here to tell you that because of the way in which you purchase supplies, which I gather up to $1.9 billion, we're paying more, 30 to 40% more than we should because of the business model that's used by hospital group purchasing organizations. I'm referring to the Greater New York Hospital

Association, which is the largest single owner of a publicly held Group Purchasing Organization otherwise known as a GPO that buys. Four large GPOs control buying for some 5,000 hospitals to the tune of $300 billion in the United States. There have been numerous investigations for Senate Antitrust Subcommittee hearings dealing with the anti-competitive contracting practices, abuses, self-dealing and legalized kickbacks of hospital group purchasing organizations. The original GPO was actually started in 1910 at Bellevue Hospital. It was a co-op like the Harvard Co-op. What happened things got off the track in '87 when a bunch of lobbyists sold Congress a bill of goods that they should pass a safe harbor whereby it exempted GPOs from criminal prosecution for taking kickbacks from suppliers, and this has created a set of for first incentives that have resulted in skyrocketing costs of drugs, devices and supplies. I'll be--my time is running out—I'd be happy to discuss this with you, make a presentation, go into detail. In the meantime we have a website www.physiciansagainstdrugshortages.com the bottom line is the Great New York—the Health and Hospitals

Corporation is big enough to be able to do its own in-house buying and not have to pay quote, unquote "legalized kickbacks" to the Greater New York Hospital Association, which get funneled through to premier and benefit only executives of these GPOs and their shareholders. Thank you.

CHAIRPERSON JOHNSON: Thank you.

AMANDA LUGG: Good afternoon, which sent the—Mr. Chair for the opportunity to testify today and as well for everything else that you do especially for our LGBT community. In the interest of time—in the interest of time, I'll-I'll keep my—I'll shorten my testimony. My name is Amanda Lugg. I'm the Director of Advocacy for African Services Committee is a community based organization up in Harlem, 30 years old where we serve the African immigrant community. Ninety percent of the sites that we serve are undocumented, and our core services are health more specifically HIV and AID and we also have five testing treatment sites in Ethiopia. I'm here to just to note how critical it is to expand on the Viral Hepatitis Initiative. African Services is unique inasmuch as we provide free Hepatitis B and C tests for everyone regardless of insurance status.

Over 70% of our clients are uninsured. We target clients for Hep B screening who were born in Africa. We accept walk-ins and do not require appointments. As a result, we are able to test patients who would otherwise not received screening. As our services are free, our organization incurs significant costs, however, in laboratory bills. In the most recent 12 months ASC test-African Services tested 486 people in our Check Hep B program, which has more than doubled over last year's statistics of 225 people tested. As of December 31, 2016, we had enrolled 74 Hep B positive chronically infected clients in the program, 100% foreign born coming from 12 countries, 70% uninsured and seven different languages were spoken among this cohort. ASC Hepatitis Program, which began with two years of CDC funding back in 2012, is urgently needed to continue to improve outcome for immigrants with chronic HPV infection in New York, which has the nation's largest population of foreign born persons with—with Hepatitis B from countries with intermediate high HPV infection prevalence primarily from Subsahar, Africa and Asia. African Services has found that most persons with CHV have not been tested, are unaware of their status and thus

receive little to no care at all reflecting the rapid growth of the African immigrant population in the U.S., which expanded from 200,000 to over 1.5 million over the last 30 years. New York City has the second largest population of Subsahar and African born immigrants in the U.S. In New York City this population has extremely high rates of chronic HPV. African Services has tracked these high rates through its cohort of 880 West African born patients who were screened for [bell] HPV over a period of 18 months. Of the 1,732 patients screened, 880 were born in West Africa with a prevalence of 11.4%, which is extremely high. I think my time is up. So my colleagues will be giving more stats on that. Thank you very much.

CHAIRPERSON JOHNSON: Thank you very much, and thanks for your patience. Thank you all for testifying.

AMANDA LUGG: Thanks.

CHAIRPERSON JOHNSON: Okay, next up Rachel Pratt, Meryl Reichbach, Reed Freeland, and Soon (sp?) Kim. Okay and then the following panel is going to be Elizabeth Adams, David Appel, Shelia— Sheila Reynoso, and Dr. Harmit Kalia. [pause] Okay, you may begin.

RACHEL PRATT: Thanks. Good afternoon, Chairman Johnson, and thank you for this opportunity to testify before the Health Committee. My name is Rachel Pratt and I serve as Senior Vice President of Youth and Community Services at New York Road Runners where our mission is to help and inspire people through running. We're here to talk to you about childhood obesity and how New York Road Runners partners with New York City to get more than 100,000 children moving each and every day. I'm also here to respectfully request City Council consideration of $500,000 in funding in Fiscal Year 2018 under the Child Health and Wellness Initiative. With these funds in the upcoming year, New York Road Runners will increase the physical activity and wellness of 150,000 New York City Children from Pre-K through grades 12 in over 800 schools. Well New York Road Runners is best known for producing the TCS New York City Marathon and other races for adults, our organization has also been New York City's largest non-profit provider of free youth fitness programming. Physical activity during childhood lays the groundwork for a healthy life. It is not an extra. It's critical for healthy development and

wellness. Children spend a large proportion of their day in school. Those in lower income communities have less access to sports. Because of this, in-school PE instruction is paramount. In the 2015-16 school year, New York Road Runners School Based Programs served day in and day out 115,000 New York City Youth. That includes 5,200 youth in adaptive physical education programs. Sixty-six percent of New York Road Runners school sites meet Title 1 requirements. For seven years New York Road Runners received generous funding from the City Council in the amount of $250,000 through the Speaker's Obesity Prevention Initiative, which was not funded in Fiscal Year 17. Instead, we've been working with the Department of Education in its MTAC process, which is uncertain and limited New York Road Runners' planning for growth. As an organization New York Road Runners invests well over $4 million in New York City youth making the requested $500,000 under the Child Health and Wellness Initiative an excellent return on investment for the city. The number of New York City students served by New York Road Runners has more than doubled since 2010, the year we initially received City Council funding. In 2016-17, New York

Road Runners will serve 124,000 New York City youth. With our Fiscal Year 18 request, we will serve 150,000 students in Pre-K through grades 12 in 800 schools, incorporate the latest research in physical literacy, feature adaptations for children with disabilities ensuring that all students can participate, align with the Shape America Physical Education Standards, which have recently been adopted by New Your City DOE. Providing robust obesity preventing physical fitness programs to 1.1 million students is a significant challenge. New York Road Runners is partnering with the City on a large scale to meet this challenge and to serve every child in New York City with fun and engaging programs that inspire them to be healthy and active for life. Thank you for allowing me to testify [bell] today. I'm happy to answer questions and I urge you to prioritize the funding of physical education and fitness programs for all New York City students.

MERYL REICHBACH: [off mic] Good evening, Chairman Johnson and

CHAIRPERSON JOHNSON: Turn your mic on.

MERYL REICHBACH: Do I need to fix it? How's that. Okay. Good evening, Chairman Johnson

and members of the committee. My name is Meryl Reichbach. I'm a Licensed Clinical Social Worker and Program Manager for Astoria Queens Sharing and Caring. On behalf of our founder Anna Quill, the Board and staff I'm here today to thank the Council for its longstanding support of Sharing and Caring, and to ask that you support our funding request of $225,000 in the upcoming budget under the Council's Cancer Services Initiative. Funding of $225,000, an increase of $75,000 over last year, would enable us to expand our community and high school outreach program to communities we're currently unable to serve due to limited resources including our partnership with the Queens Public Library. This partnership, which I initiated, has enabled us to provide important health, mental health and cancer information to an adult in an environment they trust. Council funding has enabled us to continue to be of service to those diagnosed with cancer, and has allowed us to continue our highly successful and popular Be a Friend to Your Mother high school outreach program including at Landmark High School in May 2016. Under this program Sharing and Caring educates high school students about health and

wellness, breast, prostate and testicular cancer and the importance of monthly self-exams at appropriate cancer screenings. This program, which falls under the New York State Learning Standards for Health and Physical Education has been extremely well received by students and faculty alike. This year we will have directly reached over 4,000 youth and adults through our high school library and other community outreaches, and estimate that we will have indirectly reached over 7,000 additional community members. In 2010 and earlier, Queens has had the highest rate of late stage breast cancer detection in the nation. It stood at 33% versus the national average of 12% according to the Queens Cancer Center. These numbers are going down due to efforts like the outreaches and programs we're doing in libraries, high schools and in the greater community to reach underserved and underinsured communities. Without the continued funding of the Council, Sharing and Caring's ability to continue its mission of providing direct services as well as counseling support and hope to those diagnosed with cancer is at risk. On behalf of those we serve and those whose lives are affected by

cancer, I ask for your help and leadership. Thank you.

REED FREELAND: [coughs] Hello. Thank you Council Member Johnson for chairing this—this long hearing, but we're very grateful and we will Inject Positive Housing Works. I'm here today. Housing Works would like to applaud the Mayor, the City Council and the Department of Health for your ongoing commitment to the city's Ending the Epidemic Initiative. We urge this Mayor and City Council to continue to support and build upon the Ending Epidemic Initiative and expand the City Council efforts to combat Viral Hepatitis. New York has already made history with the early success of its ET Initiative. The City's surveillance shows that between 2014 and 15 in one year the city achieved an 8.3% decrease in new HIV diagnoses. The percentage of people with HIV engaged in care who were virally suppressed increased to 83% at that end of 2015. The city has been able to get to zero while with the child transition and has decreased the number of new HIV infections attributed to injection drug use by more than 92% between 2001 and 2015 showing that supporting drug reduction programs works. Housing

Works also applauds the City Department of Health and Mental Hygiene for endorsing the New York State consensus statement on viral suppression to affirm that the now conclusive scientific evidence that people with HIV who are on anti-retroviral treatment this is—suppresses the virus to an undetectable level cannot only protect their own health, but cannot transmit HIV to others. We were very glad to see the City of Permanent Health sign on this statement. It is within our reach to get to zero AIDS mortality, the principal cause of death and zero new HIV infections via injection drug use by establishing systems to treat these avoidable outcomes as sentinel events. The approach that has enabled our city to get to zero per needle infections. We encourage the city to undertake a central event approach to mortality and new HIV infection drug use. We must continue to increase PREP and PAP services for all persons at high risk by offering comprehensive HIV prevention in new settings and in a manner that will reach currently underserved groups including women, injection drug users and others and the city must continue to promote sexual health for all New Yorkers by continuing to enhance services offered by the

City's Sexual Health Clinics, and by increasing public awareness of these clinics. We are also excited about ongoing discussions of potential developed demonstration projects to leverage the wealth of new resources available to improve outcomes for homeless and over low-income persons. Persons enrolled in HSAS and DHS represents some of the highest utilizers of healthcare services with some of the poorest health outcomes. [bell] Yet, there is current little ability for integration of care between HASA and DHS systems for involving an integrated healthcare system. New York State has invested in a Regional Health Information Organizations or RHIOs, and these platforms have not been integrated with HASA and DHS. So we encourage the demonstration projects to do so.

CHAIRPERSON JOHNSON: Reed, I got it.

REED FREELAND: Okay.

CHAIRPERSON JOHNSON: Thank you.

REED FREELAND: I encourage you to read the rest of the testimony--

CHAIRPERSON JOHNSON: We will.

REED FREELAND: --and I stand by the Viral Hepatitis group that is presenting today.

CHAIRPERSON JOHNSON: Absolutely. Thank you very much.

SARAH KIM: Good evening. My name is Sarah Kim, Hepatitis B Program Manager at Korean Community Services one of the five grantees under Check Hep B Patient Navigation Program. The—in the past fiscal year Check Hep B grantees are served with the 402 patients infected with the Hepatitis B. In this time frame, 369 patients completed a Hepatitis—Hepatitis B medical evaluation, and 134 started the treatment. Check Hep B patients their recent progress has made significant progress in connecting patients—Hepatitis B patents to a continuum of care. We do support for –we do constant support for Hep B patients in the recent program recruiting and community services have been in coordinating care for 58 Coneg happy patients to receive a liver cancer screening. 100% of the patients were born out of the United States and limited in speaking—limited in speaking English, uninsured or underinsured and in low-income. We –our cases of Check Hep B program needed to identify patients with the current—current in Hep B. So we—so we had a monthly screening event and needed educational shelves (sic) in the community

in collaboration with the faith based organizations and other community partners. Due to patients' limited resources and limited in language, there is culturally competent patient navigator—navigators assist the patients to get medical treatment. We make efforts to collaborate with the Korean speaking doctors to take undocumented patients for diagnose assistance and treatment pro bono. We develop our own language-culturally competent education and outreach materials to reach out—reach out to vulnerable Koreans in general and target patients who are not treat—who are not treated due to a lack of the knowledge and awareness. In this meeting we do—we would like to request the expansion of the Check Hep B and C programs to build our capacity. Given that the Hepatitis B and later liver disease are chronic, our patient navigator services are critical in considering Korean patients and should be continued. We looking to hire more patient navigators to get trained, identify, assist, and empower patients. To diagnose those case of liver cancer costs more than $150 for sonogram, which is a burden to uninsured patients. We hope to provide the free services for those chronic patients to get

timely and appropriate treatment. For Koreans with limited English proficiency, Korean Asian media are key information outlets. We hope to utilize more media tours to campaign the importance of care management of the occurring Hep B and to reduce the stigma stick to patients with the Hep B. We hope we can work together to secure funding to maintain our current [bell] Check Hep B programs, and to also provide our services at other sites. It is essential that we continue to connect Hep B patients to con-to care to reduce their risk of a liver disease, cancer and premature death. Thank you for your time and your patience.

CHAIRPERSON JOHNSON: Thank you all very much. Okay, the last panel. Elizabeth Adams from Planned Parenthood, David Appel, Sheila Reynoso and Dr. Harmit Kalia. [pause] You may begin.

HARMIT KALIA: Good evening, Chairman Johnson and Committee Member. My name is Harmit Kalia I'm a liver physician from Montefiore Medical Center and I'm here to request additional funding for the Check Hepatitis B program to support an additional site, Montefiore Medical Center for your upcoming budget. A lot—you've heard a lot about this program

from several other people. I won't be repetitive, but basically there are already eight programs in existence and as you've heard, the statistics from some of the other people, you know, this program provides links to care especially in the underserved population many—many foreign born. The point I want to make is that even though there are 100,000 people with Hepatitis B in New York City, given the prevalence, a high prevalence of Hepatitis B in West Africans, which are concentrated—one of the locations where they're concentrated are in—in the Bronx about 8,400 possible patients are there, and we're already taking care of them through the Montefiore Liver Program, but we do need more help. Some of the things that we've initiated in—in understanding community concerns given the current political environment providing education and raising disease awareness by doing screenings and increased—increased vaccinations when appropriate. This is all in the background of this disease that can be easily treated, and certainly good medications available, but it is a silent killer, as mentioned by somebody else. So, we--obtaining a navigator for the Check Hep B program

at Montefiore Medical Center would add momentum to our mission and I thank you for your time.

CHAIRPERSON JOHNSON: Thank your, Doctor.

SHEILA REYNOSO: Hi. My name is Sheila Reynoso, and I've working the Hepatitis C field now for six years in the Bronx. The Bronx is city where 8% of all adults and 14% of Puerto Rican men are estimated to have Hepatitis C. These are startling rates when we compare them to what's happening nationally. So I started out a Hepatitis C health educator at a substance abuse program in the South Bronx, and my goal was to work with patients, educate them about Hepatitis C, work along side providers and then also help these patients start treatment. Sometimes getting patients to start treatment was the most difficult part. A lot of our patients in our communities run into many barriers such as housing, incarceration, mental health, and then also getting connected to site care. And so I worked together with a team to help our patients overcome some of these barriers. Our goal was to never give up on our patients and those patients always came back. And so that was the most rewarding part of my job, having patients start treatment, and being thankful for

working with a team and working with a community that has often stigmatized. Unfortunately, I also witnesses patients that got treated too late, or were diagnosed too late, and so some of those patients unfortunately died from liver failure. So we've come a long way from how we used to treat Hepatitis C. It was only a couple of years ago where we had a treatment that had a lot of side effects, and that also had a low cure rate. In the last couple of years we made a big push on diagnosing patients. New York was one of the first states in 2014 where we back—where we passed the testing law, but what good does it do if we don't have the resources to make sure that those diagnosed actually get cured for a disease that, from a disease from which a cure exists. We have a program that works. We have a team at Montefiore that provides care coordination and so now I manage a team at Montefiore Project Inspire that provides care coordination to our patients. Our program started on September 2014 and it's a federal grant funded through CMS, managed by the New York City Department of Health, and this year in August 2017 we have enrolled 1,810 patients where 51% of those are Latinos and 33% are non-Hispanic

Black, which mirrors the community that we serve in the Bronx. A total of 947 patients have started treatment and 95% of those patients have been cured with more to come as we close out the grant. So again, even though we've done good, 50% of patients in the Bronx still remain undiagnosed, and so this is what we want to prevent. We want to prevent liver cancer and then also liver failure, and so we ask the City Council on this part of the Viral Hepatitis Initiative for $309--$391,600 so that we can continue to provide these services that continue to be essential to address Hepatitis C. Thank you so much for your time. [bell]

CHAIRPERSON JOHNSON: Thank you.

DAVID APPEL: Good afternoon. My name is David Appel. I'm the Director [coughs] of the Montefiore Medical Center School Health Program and a member of the Board for New York State School Based Healthcare Alliance. I'd like to thank Chair Corey Johnson and the members of the Health Committee for the opportunity to give testimony on the Mayor's Preliminary Budget for Fiscal Year 2018. We'd also like to thank New York City Council and the Committee on Health for its work and dedication to improving

Child Health Outcomes New York City. School Based Health Centers have long been a partner with you on the front lines for this work. Today we wish to share our thoughts about the important services school based health centers provide and respectively—respectfully [coughs] request more sustainable funding for school based health centers in New York City particularly in light of recent threats at the federal and state level. While efforts to appeal the Affordable Care Act have so far failed, this is a time of great uncertainty and risk for the future of Medicaid. School based health centers will be needed more than ever if federal funding for Medicaid to New York is dramatically reduced. School based health centers see every child who enters their door regardless of the ability to pay. They provide primary dental—primary dental, mental and reproductive healthcare services as well as preventive chronic health retakes (sic) of kid underserved populations. School based health center are safety net providers for undocumented children and the uninsured. For many immigrant children school based health centers are their only source of care. Currently 15% of those served in New York City

are uninsured, a number that's likely to increase in the near future. School based health centers provide integrated primary mental health, community health and dental, care for services. Services are conveniently provided on or near a school campus greatly enhancing access to health services for many families. All insured and uninsured students may receive services. They are provided at no cost. However, many of the visits to school based health centers are uncompensated. In many cases as many as 50% of visits. School based health centers have always struggled to keep their doors open. However, known and ongoing federal threats to insurance markets and Medicaid leave in doubt the extent to which school based health centers will be able to rely on stable health coverage to continue meeting their bottom lines. Changes in federal [coughs] immigration policies threaten the stability for immigrant families creating new challenges, stress and traumas for children that only deepen the need for stable access to important medical and mental health service in the community. High school—school based health centers have a proven track record of effective reproductive healthcare, HIV counseling and

testing, diagnosis and treatment of STIs and pregnancy prevention. New York City continues to close—if New York City continues to close school based health centers, [bell] the city will face increased cots for employing school nurses and more asthma hospitalization, and increase in pregnancy rates. I'm just going to go to our recommendation. We urge the Mayor and the City Council are able to allocate and baseline resources to school based health clinics to sustain operating costs so that we're able to continue for our critical services to the youth they serve. In line with allocating resources with school based health centers, we ask that the City Council amend the current New York City Administrative Code S17187, School Nurses to allow schools with school based health centers to use funding that would otherwise be allocated for school nurses to provide services through the already established clinics. Thank you again for the opportunity to testify before you today on this very important matter. Please feel free to contact me or call with any questions regarding this testimony.

ELIZABETH ADAMS: Hello. My name is Elizabeth Adams, the Director of Government Relations

at Planned Parenthood of New York City. Thank you to the committee, Chair Johnson, the Speaker and DOHMH for a continued partnership and long time support of our work. For 100 years New York City residents have relied on PPNYC for essential healthcare and educational programs. This year we face one of our toughest battles yet, and ask for your support to continue to provide expert care to all New Yorkers. Planned Parenthood New York City currently serves more than 60,000 people annually. In 2016, we added transgender hormone therapy, vasectomies and prep to our services and are proud to be a vital and innovative healthcare resource in New York. In anticipation of significant federal funding cuts in the coming year, PPNYC respectfully requests an expanded initiative of $750,000 in order to continue to serve our patients regardless of insurance, immigration status or ability to pay. This funding covers preventive healthcare services including contraception, GYN care, cancer screenings, colposcopy, male reproductive health exams, STD testing and treatment, prep, transgender hormone therapy and HIV testing and counseling for those who qualify for our services at low to no cost so that

they're full sliding scale patients. For many New Yorkers Planned Parenthood is their primary link to healthcare. In fact, 4 in 10 women who obtain care at family planning centers report it is their only source of healthcare. We anticipate that need for safety net providers such as ourselves will only increase under this new administration. Because of potential coverage changes as well as federal actions targeting immigrant communities, we expect to see more New Yorkers either losing coverage or declining to enroll in eligible coverage because of safety concerns. An expanded initiative would help—help us provide care despite federal cuts. If Planned Parenthood Health Centers are defunded through Medicaid restrictions as they're looking to do currently, we will no longer be able to accept a patient's Medicaid Insurance used by about 55% of our patients, and we would have to rely on a greater portion of our sliding scale funding. Despite last week's win, which was momentous and wonderful, this Congress and President have repeatedly committed to cutting Planned Parenthood's funding and will likely move forward in April's continuing resolution or a standalone bill to cut funding for Planned

Parenthood. We know the fight is not over. In addition to our health services, this initiative supports PPNYC's education funding including the Youth Health Promoters who connect outreach in their communities through social media and routine health workshops reaching thousand of young people each year. PPNYC also requests the Council's support for a $250,000 initiative through the Young Women's Initiative to provide Long-Acting Reversible Contraceptives, LARCs, at no cost to low-income New Yorkers and those ineligible for services. Lastly, we graciously request the Council's support of [bell] $112,000 Speaker Initiative Continuation for our Project Treatment (sic) Program. Thank you for your time.

CHAIRPERSON JOHNSON: We love Planned Parenthood. Thanks for being so patient. Thank you all for your testimony. I really appreciate you coming to testify and give us your thoughts on what we need to be doing to even [coughs] make public health better in New York City. After eight hours and ten minutes, this hearing is now 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 April 27, 2017