CITY COUNCIL
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TRANSCRIPT OF THE MINUTES

Of the

COMMITTEE ON HEALTH

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B E F O R E: MARK LEVINE
Chairperson

COUNCIL MEMBERS: Alicia Ampry-Samuel
Inez D. Barron
Mathieu Eugene
Keith Powers

A P P E A R A N C E S (CONTINUED)

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NYC Department of Health and Mental Hygiene

Dr. Oxiris Barbot, First Deputy Commissioner
NYC Department of Health and Mental Hygiene

Sandy Rozzo, Deputy Commission for Finance
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Stephanie Ruiz, Social Workers, Live On New York
Erica Lessem, Treatment Action Group, TAG

Shakti Castro, Community Engagement Coordinator
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Isabella Aveeno, Outreach Coordinator, Access to
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Elaine Hunter, Samaritan Suicide Prevention Center

Robin Vitale, Vice President of Health Strategies NYC
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Michael Rogers Vice President
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Felicia, Rising New York Road Runners Youth
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Anna Krill, Founder and President
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Melissa Tarks, ME Coalition

Joel Ernst, Professor, NYU School of Medicine

Danielle Christianson, God's Love We Deliver

[sound check]

CHAIRPERSON LEVINE: Good morning everybody. Welcome. We're going to get started. I'm Mark Levine, Chair of the City Council's Health Committee. Today, we'll be reviewing the Department of Health and Mental Hygiene's $1.6 billion Fiscal 2019 Operating Budget specifically the approximately $649 million allocated for public health. We'll also address the health related performance indicators from the Fiscal 2018 Preliminary Mayor's Management Report, and the department's $568 million Fiscal 2019 Preliminary Capital Budget, and Commitment Plan for Fiscal 2018 to 2022. With the Trump Administration waging a multi-front assault on our nation's public health system, the work of New York City's Health Department has never been more important. As the White House and Congress work to dismantle the Affordable Care Act, to gut clean air and water protections, to cut funding for health research, to undermine protections in the healthcare system for immigrants, LGBTQ people, women and others, and to redefine sexual health policy as being primarily about abstinence, New York City must redouble our efforts to protect the health of our communities, and

we must engage in this fight without the certainty of consistent funding from the federal government, funding which comprises an inordinately large portion of the Health Department's budget. DOHMH receives federal grants--federal grant funding for vital public health programs including nearly $100 million for Ryan White HIV Emergency Relief; $10 million for daycare center inspections; and nearly $3 million for temporary assistance for needy families. Neither these nor and federal funding stream in the realm of human--of health and human services should be considered safe in the Trump era. In fact, the danger of federal cuts is not just hypothetical, it's already happening. DOHMH receives a $1.2 million grant in the current fiscal year for its Teenage Pregnancy Prevention Program, an evidenced based cost-effective program, which helps to avert teen pregnancy and its associated health risks for teen mothers and their children. This funding has now been eliminated nationally as part of cuts to Federal Family Planning Grants. Similarly, DOHMH receives more than $5 million from the Prevention and Public Health Fund, PPHF, grants which were established in the Affordable Care Act, but the continuing

resolution enacted by the federal government in December completely cuts this funding nationally and locally. The city will have no choice but to step in to fill these gaps, and to fund expansion of programs that address other threats from Washington. They city's Get Covered NYC Initiative received a notable success this year in signing up an additional 80,000 New Yorkers for health care under out state's exchange despite relentless, rhetorical and policy attacks on the ACA by the White House and congressional leaders. But there remain an estimated 350,000 New York City residents who are eligible for healthcare and have not yet enrolled. We need to ramp up outreach efforts to solve this problem. It's critical that we invest in connecting our city's estimated 300,000 adult undocumented immigrants to primary healthcare as well building on the success of the Action Health Pilot Program. This will not only yield benefits in health outcomes, it will save much needed money in our struggling public hospital system. Commissioner Bassett deserves enormous credit for the department's intense focus backed by real resources on tackling persistent health inequities in our city, but we know that much more

work remains. A 2016 analysis of five years of New York City data found that black college educated mothers who gave birth in local hospitals were 12 times more likely to suffer severe complications of pregnancy in child birth than white women who never graduated from high school. Other data tells that despite reaching a record low number of new HIV diagnoses in the city in 2016 there was a 5% increase in new HIV diagnosis among women compared to the prior year. Black and Latino women comprise more than 90% of all newly diagnosed women, and children in low-income communities of color still face disproportionately high rates of asthma, lead poisoning, obesity, dental carries and other conditions. The department's community based health action centers in East Harlem, the South Bronx and in Brownsville show enormous promise for helping to tackle these disparities. We need additional centers in major low-income parts of the city, which are currently underserved including Jamaica, Rockaways, and the North Shore of Staten Island. I look forward to discussing these and other vital issues with the administration and members of the public today, and I would like to thank my committee staff Janet Merrill,

Crystal—Crystal Pond and Zaya Manuel Helou (sp?) for the hard work in preparing for this hearing, and I'm pleased to have been joined by stalwart committee Alicka Ampry-Samuel who gets bonus points for punctuality, and now I'll ask our committee counsel to administer the affirmation for the Administration.

LEGAL COUNSEL: Do you affirm to tell the truth, the whole truth and nothing but the truth in your testimony before this committee and to respond honestly to Council Member questions?

COMMISSIONER BASSETT: I so affirm. Good morning Chair Levine and I hope soon to be members in plural of the committee. I'm Dr. Mary Bassett Commissioner of the New York City Department of Health and Mental Hygiene, and I'm joined by Dr. Oxiris Barbot, our First Deputy Commissioner, and Sandy Rozzo, Deputy Commission for Finance, Thank you for the opportunity to testify on the department's Preliminary Budget for Fiscal Year 2019. I'm looking forward to working together to improve the health of all New Yorkers. As this is our first budget hearing together, I'd like to share a bit of background on the department and the principles that guide our work. Our organization covers a wide range

of health topics and I'm proud to say that that the department's staff represents the very best in their fields. Our policies and programming on topics as varied as tobacco, restaurant grading rats and HIV are widely considered to be the told standard nationally and internationally, and while the work we do is guided by data and science, under my tenure as commissioner have adopted a values based approach to public health, one where equity is central to our work. In this great city, your zip code should not determine your health. Core to our values at the department is our conviction that ever and every community should have the opportunity to live their healthiest lives. The focus on equity is critical because although we are making measurable progress in helping New Yorkers live healthier lives, the data show that black and Latino residents often experience higher rates of disease than other New Yorkers. It's important to note that this is not due to biological differences by race. Indeed, we are quite literally all human. Instead, structural racism and a long history of racial and economic inequality have led to these inequities in health. We know that racism, sexism, xenophobia and other forms of discrimination

affect physical and mental health outcomes, and we know that where you live, learn, work and play matters. By acknowledging these realities and focusing on the social determinants of health such as housing, education, and transportation along with more traditional public health issues the department has adopted strategies that make our work more effective. Chair Levine, I know that you and Speaker Johnson share these beliefs and I was gratified that your first hearing focused on our Center for Health Equity and its leadership in this endeavor. I will now turn to some programmatic highlights before discussing the Fiscal Year 2019 Preliminary Budget. The department has had a busy 2017. We are proud to have made several recent announcements regarding capital projects including last week's grand reopening of the Chelsea Sexual Health Clinic and the selection of a location for the Bronx Animal Shelter. We also released the LGBTQ Bill of Rights, which reiterates that healthcare providers and their staff are legally obligated to provide LGBTQ people with high quality healthcare. It is both wrong and illegal to provide lower of quality of care because of sexual orientation, gender identify and/or gender

expression. In 2017, we also launched the Maternal Mortality Morbidity Review Committee, which brings together healthcare providers, community based organizations, researchers and first responders to review maternal deaths and "near misses" collectively learn from these tragedies. Severe maternal morbidities are pregnancy related complications that threaten the health of the mother. These represent one of the starkest health disparities in our city, one that you've just alluded to, a black woman with a college degree or higher is more likely to have serious complications during child birth and a white woman with less than a high school education. They review committee will increase our vigilance and understanding of these events, and it's just one of the department's efforts to address this very serious public health issue. Finally, together with the Council we worked to pass a package of tobacco related bills that keeps New York City at the forefront of tobacco control in the nation. Tobacco use remains the leading cause of preventable deaths in the United States, and there are still more than 850,000 adult smokers in New York City. These new laws will help decrease the number of smokers by

160,000 by 2020 saving many lives and bringing New York City's smoking rate to a historically low 12%. I will now turn to the Preliminary Budget. The department currently has approximately 6,000 employees and an operating budget of $1.6 billion of which $700 million is city tax levy. The remainder is federal, state and private dollars. In fiscal year 2019 Preliminary Plan the department received an additional $3.5 million for co-response expansion on NYC Safe, $1.1 million for comprehensive drug and alcohol misuse program to help address substance use issues among LGBTQ youth and $1 million to implement the Neighborhood Rat Reduction Plan. Last summer the Mayor announced the city's neighborhood Rat Reduction Plan a $32 million multi-agency [coughing] initiative. The bills on the department's existing and successful rat reduction programs, and focuses on neighborhoods with the highest burden of rat activity. For Fiscal Year 2019, the department has been allocated $1 million to hire staff, purchase rat resistance waste receptacles known as big bellies, developed a widespread public awareness campaign and stand-up stoppage teams to plug rat burrows. Through the plan we are implementing innovative rat

prevention inspection and control approaches with our sister agencies, and we are looking forward to conducting a robust evaluation of these efforts and anticipate seen measureable declines in rat activity in targeted areas. Though we have a separate budget hearing on this later today, I want to acknowledge our ongoing work to address mental health and substance misuse. We are now in the third year of the city's Thrive NYC Initiative and beginning the second year of Healing NYC. Just yesterday the Mayor and the First Lady announced an additional $22 million per year to address the opioid epidemic. This will include funds for the department to expand the Peer Intervention in Hospitals Program, establish the end overdoes training institute to train New Yorkers on how to administer Naloxone, and expand crisis response services to address the health needs of individuals referred to us through law enforcement and first responders. We are grateful for this continued funding from the City, but reductions in resources at the state and federal levels have deep and tangible effects on services we are able to provide to the public. As the Governor and legislature finalizes the State's Fiscal Year 2019

Budget this month, I'd like to flag for you two areas for—of concern for the department. First, over the past ten years, funding for Tuberculosis control efforts has declined by nearly 50% including a 20% state reduction last year in a proposed reduction in Fiscal Year 2019. This is particularly concerning because for the first time in several decades, we are seeing an increase in TB cases in New York City. There was a 23% increase in the first four months of calendar year 2017 compared to the same period in calendar year 2016. Additionally, there was a 20% state cut to school based health center grants in fiscal year 2018. Through these centers students can access comprehensive medical care, dental, vision and mental health services at no out-of-pocket cost. As a result of this budget reduction, school based health centers have already begun to close, and as many as 20 may be forced to close to their doors at the end of the current school year. Given the uncertainty at the federal level, now is not the time to cut healthcare services provided by these safety net institutions. I'm thankful that the Assembly addressed these concerns in their one house budget bill. I encourage you to speak to your state

colleagues about the need for robust public health funding by both the city and the state to keep New Yorkers healthy. Finally, I'll turn to the current environment at the federal level. Through policy proposed and proposed budget cuts in tens of millions, the White House has made clear that it does not share our mission of protecting the health of all New Yorkers. The words diversity, fetus, transgender, vulnerable, entitlement, science based, evidence based have been chided as "bad words" by this federal administration. But they will remain at the core of what we do at the department day in and day out. As public health experts, it is our job to acknowledge and address health inequities. It is our job to use evidence based approaches to prevent the leading causes of death including heart disease and cancer. Despite the continue tax on Prevention and Public Health Fund, it is our job to respond to disease outbreaks. To dismantle the Affordable Care Act and Medicaid, it is our job to ensure that everyone regardless of immigration status has access to healthcare, and it is our job to speak out as people continue to die due to lax gun control laws and the inability of the Centers for Disease Control and

Prevention to conduct research on the subject. Regardless of what terms Washington deems permissible, we will continue to serve vulnerable populations, embrace diversity and use evidence and science based solutions to protect and promote the health of all 8.5 million New Yorkers. We are able to do this because of the rich network of local elected officials, community based organizations, and members of the public with whom we work. I want to thank the Mayor and the City Council for sharing our commitment to public health, and I look forward to the next four years of partnership. I'm happy to answer any questions.

CHAIRPERSON LEVINE: Thank you, Dr. Bassett. I want to acknowledge we've been joined by Health Committee member Dr. Mathieu Eugene. Welcome. I just want to understand this Dr. Bassett. So, we're facing an increase in Tuberculosis cases. I think you said it was 23% an increase over the prior year, but we're facing a decrease in funding.

COMMISSIONER BASSETT: That's correct, but let me just correct one thing. The data that I cited for you are from the—you saw them in the Preliminary Mayor's Management Report, are for the

first four months of—of the—this calendar year 2017 compared to the previous four months of 2016. So, it's not whole year numbers.

CHAIRPERSON LEVINE: So, that would be--

COMMISSIONER BASSETT: [interposing] But in any case, it went up by 23%, and we know that when we look at our year-on-year numbers we will have an uptick in Tuberculosis cases, and then that's what has been cut. That's correct.

CHAIRPERSON LEVINE: And it has been cut by—by—because of the state's budget in the prior fiscal year. Is that correct?

COMMISSIONER BASSETT: It's been cut and cut over the last decade, reductions in federal funding as well as the reductions in state funding, and reductions frankly by the city—by the city as well, but--

CHAIRPERSON LEVINE: [interposing] What—what is the budget today?

COMMISSIONER BASSETT: Most recently, the—the—the most recent assault has been proposed state cut of 20%, and last year we took a 20% budget cut. We'll be unable to patch over service

requirements that as currently delivered in the program unless we can adjust this budge gap.

CHAIRPERSON LEVINE: So--

COMMISSIONER BASSETT: [interposing] In terms of the total budget for the TB program, it's $14 million.

CHAIRPERSON LEVINE: And what was it at its peak?

COMMISSIONER BASSETT: It was at least twice that. We used to—you know, we have cut our number of staff in half. We now run only two clinics full time. Two clinics are open on a part-time basis so we have four clinics citywide, and as I said there's been an uptick. For those of us who've been around for a while, this has an eerie echo with prior experience the TG program was cut, and we saw the rates of TB go up. We don't want to see that happen again.

CHAIRPERSON LEVINE: And—and unfortunately, the people who are most vulnerable to TB are people who are suffering from other conditions including I believe HIV and other--

COMMISSIONER BASSETT: [interposing] That's true and that underlay the—the historic up

crease—uptick, but now we have been making great progress with addressing the HIV prevalence in our population, and putting people on treatment. Most of the people who have TB in our city are people who acquired infection in another country. They're immigrants mostly from Asia and also Latin America.

CHAIRPERSON LEVINE: Well, we will certainly join you in the fight for—against he cuts from Albany, but you're also saying that the city has cut funding to the program. Is that correct?

COMMISSIONER BASSETT: That's true, but as I just reiterate those recent cuts that one that we're most concerned about right now have been by the state--

CHAIRPERSON LEVINE: What is the city's--

COMMISSIONER BASSETT: -- at borough level. (sic)

CHAIRPERSON LEVINE: --what's the city's contribution to the $14.4 million?

COMMISSIONER BASSETT: I'll—I'll have to—I can—I can ask--[background comments] It's 64%. [laughter]

CHAIRPERSON LEVINE: Okay. Alright. So, that's about $10 million then.

COMMISSIONER BASSETT: [interposing] But we have Article 6 Match on our--

CHAIRPERSON LEVINE: About $10 million let's call it.

COMMISSIONER BASSETT: Yeah, that's it.

CHAIRPERSON LEVINE: So, what would that have been in this peak?

COMMISSIONER BASSETT: I'll—I'll have to get you the historic budget numbers, but in aggregate I can reiterate that we've seen a 50% reduction in funding for TB over the last decade.

CHAIRPERSON LEVINE: Alright, well, I'm—I'm all for pushing back on state cuts, and we'll join you and advocates in that fight, but we also have to hold ourselves accountable.

COMMISSIONER BASSETT: Yes.

CHAIRPERSON LEVINE: And if we're cutting our own budget, that what—we have to share some of the blame, too.

COMMISSIONER BASSETT: Yes and we are in discussions about the TB budgets here at City Hall.

CHAIRPERSON LEVINE: Okay, if I'm not mistaken, there are 650,000 uninsured adults in the

five boroughs. Tell me if I have my numbers approximately right, and--

COMMISSIONER BASSETT: That's approximately right.

CHAIRPERSON LEVINE: Okay, and bout 350,000 of them are eligible for some form of insurance. That could an essential plan on the state exchange for example. In some cases they could even be eligible for Medicaid, yet have not signed up. It is so important that we get those people signed up for their own health first and foremost, but as you well know, this has implications for the whole city and partly because the health of one New Yorkers due to contagious diseases, affects the health of all of us, but there's also a colder financial incentive, which is that our public hospitals are losing money everyday because they can't bill through federal and state funding streams for these patients. So, this is—it's so imperative, and I want to congratulate the city on signing up an additional $80,000 this year under Get Covered NYC. In this climate with the tax on Obamacare, that's amazing. I think people who are not informed might have thought when they see the headlines that the program is imploding and might be

discouraged form applying. Yet is doesn't ring very important that they do so. We have a lot more work to do. We have 350,000 more people that we need to get signed up. Can you explain the funding we're allocated-we've allocated to this effort, the staffing we've allocated. Some who actually are DOHMH employees, but there are—this is really a multi-agency effort. Could you explain the broader picture of—of how the city is attacking this challenge?

COMMISSIONER BASSETT: The—the first—the first activity of the department has been to ensure that everybody who's is eligible for healthcare coverage under the Affordable Care Act signs up for it, and through those efforts we've made enormous strides in reducing the number of uninsured people. It now stands—it's something under 8% of adults in the cit. We've reduced it by at least 30% with the advent of the Affordable Care Act, and the Health Department works with the other—other groups in the city, other city agencies including an active—a group at City Hall that is responsible for public outreach and our—our colleagues at Health and Hospitals to promote enrollment in getting people covered. So,

getting covered has been a key activity. We have our own enrollers. We enroll at clinics and at pop-up sites, and have contributed in getting towards that 80,000 number that you—that you complimented us on, and I want to thank you for that. That's our principal contribution to make sure that people who can get covered, get covered. Additionally, there are people, as you're aware, Mr. Chairman who are—who are not eligible under the Affordable Care Act.

CHAIRPERSON LEVINE: Well, I want—you—you mean people who—thought they are citizens and legal residents aren't eligible because of their income?

COMMISSIONER BASSETT: No, there are very few of those.

CHAIRPERSON LEVINE: Right.

COMMISSIONER BASSETT: The—the main people cut of the Affordable Care Act are being documented.

CHAIRPERSON LEVINE: Alright, I got an answer, which I—I want to talk about. That's of great importance to—to me and to the committee, but just to focus on the issue of again, people who are insurable under the current system. What—how many

staff are you devoted—have you devoted out of DOHMH to this effort?

COMMISSIONER BASSETT: I'm going to ask if I can be joined by one of our Deputy Commissioners, but we have—we have 30 Certified Application Counselors who do insurance enrollment. As you know, this is a complex process. Everybody who has ever had to pick their insurance plan knows that it's hard to decide among the many options. So, it's quite time consuming and we have 30 certified application enrollers who work with members of the public to sign up for health insurance. We do this in multiple languages meaning that we have people who speak both English, Spanish, and Cantonese I think it is, but additionally we have an interpretation line, which enables us to work with people in—in literally in scores of languages.

CHAIRPERSON LEVINE: Right, and so what is the budget for our enrollment efforts? [pause] Okay. Sorry, if you could just--

COMMISSIONER BASSETT: Just introduce herself.

CHAIRPERSON LEVINE: Yes, and we'll—we'll do the affirmation.

DEPUTY COMMISSION ANGEL: Sonia Angel, Deputy Commissioner.

LEGAL COUNSEL: Do you affirm to tell the truth, the whole truth and nothing but the truth in your testimony before this committee and to respond honestly to Council Member questions?

DEPUTY COMMISSIONER ANGEL: Yes, I affirm.

COMMISSIONER BASSETT: So, the question was: What is our budget and I have it in my book, but I don't have it in my memory, and our budget is over and above our usual. It was—for the Get Covered campaign we got no additional funding. So, we used our usual budget for our 30 certified application rolls. [pause]

DEPUTY COMMISSIONER ANGEL: Funding. Sorry, excuse me.

MALE SPEAKER: Take your time.

CHAIRPERSON LEVINE: You're—so you're looking for the budget—the—the budget line for this? Is that right?

COMMISSIONER BASSETT: [off mic] Yeah, and if you don't want it. If you—I mean we—we have whatever we gave to the individual.

CHAIRPERSON LEVINE: But there was also a large advertising budget.

COMMISSIONER BASSETT: Oh, yes, that did come out of our budget. That was run out of—we may have—we were involved in the development of that campaign, and the—it may have passed throughout budget, although it didn't--

CHAIRPERSON LEVINE: What budget if not the Health Department?

COMMISSIONER BASSETT: The—the HRA. It's the Department of Social Services.

CHAIRPERSON LEVINE: Got and do you know

COMMISSIONER BASSETT: --but--

CHAIRPERSON LEVINE: [interposing] the staff, the staffing at HRA—the staffing that HRA allocates to this or any other agencies?

COMMISSIONER BASSETT: I don't. I don't know the staffing. I mean this has been a—a—a big commitment of the Administration as you point out in your remarks. One of the key ways that we see of defending the Affordable Care Act is to ensure that people sign up and get their coverage. As long as it's available to us that we ensure that the public is aware of it, and utilizes it. As a state we had

record numbers of people signed for the Affordable Care Act. I think proof that despite all of the efforts from Washington to try and describe it as hugely unpopular that people need and are using this—this coverage.

CHAIRPERSON LEVINE: Right. I am all for having city government workers focused on this especially if they're already interacting with members of the public that would be common at HRA. There are going to be some New Yorkers who are not comfortable walking into a government office to do this, and so there's a parallel effort of CBO based--

COMMISSIONER BASSETT: [interposing] Yes.

CHAIRPERSON LEVINE: --enrollment as well.

COMMISSIONER BASSETT: Yes.

CHAIRPERSON LEVINE: And what is our budget for that piece?

COMMISSIONER BASSETT: Yes, that is not something that we budget to the Health Department. We do enrollment in fed, you know, non sort of social benefits offices basically at our health clinics and additionally we've been experimenting with using pop-up sites in communities to do enrollment.

CHAIRPERSON LEVINE: Right. Okay.

COMMISSIONER BASSETT: So, the additional services that you're talking about we'll just have to turn to our sister agency to get the budget from them.

CHAIRPERSON LEVINE: Right. The—the state does fund significant CBO--

COMMISSIONER BASSETT: Yes, they do. For—the Community Service Society--

CHAIRPERSON LEVINE: [interposing] Yes.

COMMISSIONER BASSETT: --I know has a huge grant from the state and has been very active in enrollment both in our city and across the state.

CHAIRPERSON LEVINE: So, of the 80,000 that were enrolled this year, how many came from CBOs? How many came from your department's outreach? How many came from HRA?

COMMISSIONER BASSETT: I can give you the number that came from our department, but I can't give you those other numbers, and it will take me a moment to dig up the numbers that came from our department, but it—we were proud of our efforts, and let's see what I have. Do you have that?

DEPUTY COMMISSIONER ANGEL: We do have it. We have it.

DEPUTY COMMISSIONER ANGEL: Because this was a combined effort across the city working with the Mayor's Office with HRA, the Public Engagement Unit I think is what you're referring to also in terms of the boots on the ground. We have the aggregate estimate because it was indeed a combined effort. So, the PEU for example would identify people and refer to our Certified Application Counselors as well as potentially the whole network throughout the city. We actually had in part of the referral process, we tried to make it as convenient as possible for individuals who are identified in need of insurance. So, if—if our site was not necessarily the best site for them, we would refer them to others. So, 80,000 includes the combined effort of Get Covered NYC, which was the City's initiative.

CHAIRPERSON LEVINE: Okay.

COMMISSIONER BASSETT: I think we could probably dig up a number for you if it matters to you, but I think the—the—what I hope is important to the Health Committee is that as a city we have been

committed getting people signed up, and we have exceeded our goal. The Mayor challenged us to deliver 50,000 individuals and as you've said, with the number that was—that the city enrolled was 80,000.

CHAIRPERSON LEVINE: Right. Well, I'm challenging us to get to all 350,000. That is a big challenge. It's ultimately doable. It will yield huge benefits in the health of New Yorkers and fiscal benefits as well. It seems to me that we need we need to allocate more resources in that fight. It seems like we have to invest more as a city on the CBO side, and it seems like we need interagency coordination here so that we understand across agencies at any given moment the level of resources, and just what it's yielding. To me this is a smart investment. Alright.

COMMISSIONER BASSETT: I'm just a--

CHAIRPERSON LEVINE: Alright, I'm going to pause and see if my colleague Council Member Ampry-Samuels has a question. Please do.

COUNCIL MEMBER AMPRY-SAMUELS: Good morning everyone. The question is related to lead poisoning. The Fiscal 2019 Preliminary Budget

allocates $8.5 million to the Bureau of Environmental Disease and Injury Prevention. This includes funding to reduce environmental hazards in the home associated with injuries and disease such as lead poisoning. While lead poisoning has nearly been eliminated in many neighborhoods, certain New York City districts continue to experience elevated lead levels. A recent waters investigation found 69 New York City census tracks where at least 10% of small children screened over and 11-year period from 2005 to 2015 had elevated led levels. How does the department ensure it directs its lead prevention and abatement resources to the city's neediest neighborhoods?

COMMISSIONER BASSETT: Thank you, Council Member for that question. If I could just—since I have the mic, clarify something for the Chair. There are no—there have been no cuts to the TB program by the city under my term as—as Commissioner under this administration.

CHAIRPERSON LEVINE: Go it. Just there were cuts under the prior administration.

COMMISSIONER BASSETT: Correct.

CHAIRPERSON LEVINE: But we didn't restore those cuts.

COMMISSIONER BASSETT: Correct.

CHAIRPERSON LEVINE: Okay, well—

COMMISSIONER BASSETT: That—that's good.

CHAIRPERSON LEVINE: Well, we'll be pushing for that.

COMMISSIONER BASSETT: Alright, Council Member. I appreciated a question about lead poisoning. As you point out, that we have different levels of exposure across different parts of our city, and mostly related to exposure to deteriorated lead paint in parts of the city that have older housing stock. I want to take the opportunity to show Health Committee members this graph. I know you can't make out the numbers, but I'm sure you can see the—see the overall idea here that we have had a huge reduction in the number of children with elevations above the CDC surveillance level of 5 micrograms per deciliter. Over the past now—over decades since 2005 when the Local Law 1 went into effect the overall decline has been 87% in the proportion of children with elevated blood lead levels.

CHAIRPERSON LEVINE: But could you just give us. I couldn't read that. I don't know if my colleague could, but

COUNCIL MEMBER AMPRY-SAMUEL: Those are what we're hearing.

COMMISSIONER BASSETT: I think exactly what we're providing.

CHAIRPERSON LEVINE: [interposing] So, what—what was the first year on that charter and what was the level and what was the last year, I guess that's—

COMMISSIONER BASSETT: Okay, this is—these are numbers of children with blood lead levels above 5—5 micrograms per deciliter, which is the surveillance criteria used by the Centers for Disease Control. That cut point was selected because 95% of children had blood lead levels lower than that. Now, in 2005 we had 37,344 children who fell in that category with blood lead levels great then 5 micrograms, and the rate per thousand children tested was 120.4. In 2016, the most recent data for which we have—the most recent year for which we have data available we had 4,928 children with blood lead levels above 5 and the rate was 16.5 per 100 per

1,000 children tested. As I said, that represents an 87% decline. So, I want to make clear that as a city historically we've been very aggressive on blood lead—on exposure to lead and on the identification and remediation of exposures, and when we identify all the blood lead levels in children. That-part of our success has been focusing on areas where we have particular concern, and I'm joined by Deputy Commission Corinne Schiff who leads our Environmental Health Program. I'll ask her to speak to those special programs that focus on areas where children have more exposure.

COUNCIL MEMBER AMPRY-SAMUEL: Okay, and can you also provide us with information as to where those particular areas are? That would be helpful.

DEPUTY COMMISSIONER SCHIFF: Sure. So I think it's just—

CHAIRPERSON LEVINE: Sorry. We just need to do the affirmation.

DEPUTY COMMISSIONER SCHIFF: Oh, yeah, Corinne Schiff. I'm the Deputy Commission for Environmental Health.

LEGAL COUNSEL: Do you affirm to tell the truth, the whole truth and nothing but the truth in

your testimony before this committee and to respond honestly to Council Member questions?

DEPUTY COMMISSIONER SCHIFF: Yes. So, to—first to provide some—some context, the City has a—a multi-faceted approach to—to lead poisoning prevention. As you probably know, every year, tenants receive a notice from their landlord asking them to indicate whether there's a child under six in the apartment and then the property owner has an obligation to check that apartment for peeling paint. The Department of Health's role is to intervene when there's a child with an elevated blood lead level. So, every day we get a download of all blood lead testing results from New York City, and every day our Healthy Homes Program reviews those results to find children with elevated blood lead levels. We then very quickly follow up with the family to make an appointment and we do a very, very comprehensive risk assessment with that family to try to identify every source of lead exposure for that child. We also do an investigation in the home using a piece of equipment called an XRF. We literally point at the wall for every place where the paint is not intact to take a measurement and to see if that paint is lead

paint is lead paint. If it is, we then order the property owner to remediate. The property owner has only five days to begin that work. We then monitor that work to make sure that it's being—being conducted, and if it's not we make a referral to HPD, which then does complete the—the abatement and the property owner will receive a violation from us subject to fines. So, that sort of in brief the—the approach that we take and as Dr. Bassett has point out, we've had really quite a lot of success since Local Law 1 has gone into effect. We do also have a very active surveillance program. So, we know where in the city there are hot spots. As—as you have noted it's not equally distributed throughout the city. The main exposure for children remains lead paint, and so it's really tied to the—the housing stock and the—the quality of the—of the—of the housing stock. And so, for example some of the areas where we're doing a lot of work are in Williamsburg in Brooklyn and we take a really community based approach working with organizations, local organizations in those communities to—to reach tenants, to reach property owners, property managers, teaching them about abatement, safe work. A very

multi-faceted approach to that, but every child where we receive a result of an elevated blood lead level gets our attention.

COUNCIL MEMBER AMPRY-SAMUEL: Okay, and just one last follow-up. Okay. Has the city addressed the potentially unsafe lead levels in the back yard soil of some of the homes in the Greenpoint, Brooklyn area? You mentioned Williamsburg, but I received notice about Greenpoint.

COMMISSIONER BASSETT: Yeah, you were speaking about lead in the soil?

COUNCIL MEMBER AMPRY-SAMUEL: Yes.

COMMISSIONER BASSETT: Well, we—again the principal exposure that we find is exposure to a deteriorated lead paint. So, that means both flicking paint and something that we call lead dust, which is from—it's literally dust that accumulates as the paint chips deteriorate. Exposure to lead in the soil is not a key exposure for elevated blood lead levels, but when we learn of it, we do work with the Department of Environmental Protection that—that—

COUNCIL MEMBER AMPRY—SAMUEL: [off mic] Yeah, and that's Deputy Commissioner. (sic)

DEPUTY COMMISSIONER SCHIFF: And we do—we do-there have been some reports, as Dr. Bassett has mentioned lead paint is really the primary exposure. Lead poisoning results from ingestion, and so concerns about back yard soil could be when children are playing and—and literally eat when they're playing in the dirt, and children, as we know, put their hands in the mouth. We have guidance for people about—if they're going to do gardening in their back yard to use raised container beds for—for that gardening, to-to wash toys, but really our primary concern is paint.

COUNCIL MEMBER AMPRY-SAMUEL: Alright, thank you.

CHAIRPERSON LEVINE: Thank you, Council Member. So, I just want to emphasize a point you touched up that while we've made great progress as your graph showed citywide, there are pockets of the city where the rates are alarmingly high. I think as high as 10% in some neighborhood? Ten percent of the kids—do I have that right in some neighborhoods are testing positive, which is higher than Flint. Let me—let me look at the—I'll get the number for you

here. [pause] Great. So, we talked about Williamsburg in Brooklyn for example--

COMMISSIONER BASSETT: Williamsburg, yes.

CHAIRPERSON LEVINE: --if the rate is not 10%, can you tell me what you would expect it to be in the worse neighborhoods.

COMMISSIONER BASSETT: I am not aware of neighborhoods, whole neighborhoods that have a rate of 10%--

CHAIRPERSON LEVINE: Okay.

COMMISSIONER BASSETT: --or even sectors of the population say by—by income group that have—break that line.

CHAIRPERSON LEVINE: [interposing] I'm-I'm—I'm looking at--

COMMISSIONER BASSETT: [interposing] But there are—there are, certainly this is what people used to refer to as a lead belt in Brooklyn, and Williamsburg is at the heart of that area. That's why we have additional efforts to ensure that that community is aware of its potential to that exposure.

CHAIRPERSON LEVINE: Right. So it looks like Reuters did and investigation on this data from 2005 to 2015. Over that 11-year period they found 69

New York City census tracks where at least 10% of small children screened had elevated blood levels.

DEPUTY COMMISSIONER ANGEL: Well, as Dr. Basset said, we do have particular interventions in hot spots like Williamsburg and we're working. The—the housing stock [coughs] in that neighborhood is—is old and crowded, and that leads to degradation—further degradation of paint, and additional risks for children, and so we have had a special focus in that community to reach families. Parts of that community are very insulated. So, we have been doing our work through the community based organizations who are best able to—to reach families in—in the language that they use to make sure that families know about bringing their children for testing, and also to work with the property managers there to make sure that that they understand the law about inspecting apartments and correcting—

CHAIRPERSON LEVINE: [interposing] My, my notes say that it's in the Hasidic neighborhood section of Williamsburg.

COMMISSIONER BASSETT: That's correct.

CHAIRPERSON LEVINE: So, do we have Yiddish language outreach?

DEPUTY COMMISSIONER SCHIFF: We do.

CHAIRPERSON LEVINE: Do you have staff, Yiddish speaking staff?

DEPUTY COMMISSIONER SCHIFF: We have—our publications are in Yiddish and let me—[pause]

COMMISSIONER BASSETT: Yes, that we would have very detailed questions. So, we need to bring up the people who are—

DEPUTY COMMISSIONER SCHIFF: So, we-so we do that—

CHAIRPERSON LEVINE: [interposing] We aim to deliver on that promise. [laughs]

DEPUTY COMMISSIONER SCHIFF: So, we, our—we have publications that are in Yiddish, and we do the work through the community based organizations not only for—for reasons of language, but for reasons of—for cultural access. So, our work is through—we fund community-based organizations and we work with them to—to—to train them and to deliver those messages. So it's in—it is in the—the spoken language.

CHAIRPERSON LEVINE: So, you're funding community based groups in the Hasidic areas of Williamsburg?

DEPUTY COMMISSIONER SCHIFF: Yes.

CHAIRPERSON LEVINE: Okay, we'd like to follow up with on that for sure, but I want to turn to the opioid crisis which—which you have been focused on and correctly addressed in your open remarks, and we were excited about the announcement yesterday of additional resources, additional strategies. As you and I have spoken about, this is a tough disease to shake, opioid addiction. Am I right to use the word disease in this context?

COMMISSIONER BASSETT: It's certainly preferable to crime.

CHAIRPERSON LEVINE: Okay, well, I—I would-would not make that mistake. It is properly understood a public health challenge. I think we would all agree on that.

COMMISSIONER BASSETT: That is correct.

CHAIRPERSON LEVINE: And the success rates of people who completely kick this addition is vanishingly small. That does not mean that opioid addiction has to be a death sentence, and it doesn't even mean that people who are struggling with this addition cannot lead productive lives. There are many, many examples of people who have been able to

manage this condition. We have—and instituted some innovative—innovative strategies to help do that one of which is needle exchanges, which 20 years ago were considered radical and risky, and today I think are accepted almost universally in the public health landscape as just being a smart—a smart and evidence supported intervention. We are engaged in a similar today—a debate today about safe injection facilities, which provide a professionally supervised setting for people to self inject, which can prevent fatality and can provide a context to offer wraparound social services, which we know are so important and effective. Do—do you accept what I think is an emerging consensus of the effectiveness of these sites?

COMMISSIONER BASSETT: I think that the public health literature is clear.

CHAIRPERSON LEVINE: The public health literature is clear in establishing the effectiveness--

COMMISSIONER BASSETT: That's correct.

CHAIRPERSON LEVINE: --of those sites. There are—there are other parts of the world, which

are already successfully instituting such programs, correct?

COMMISSIONER BASSETT: Not in the United States.

CHAIRPERSON LEVINE: Right, other parts of the world—other countries, though?

COMMISSIONER BASSETT: That's correct.

CHAIRPERSON LEVINE: Correct. So, we're—we're—we're behind the times on this domestically. So, I'm going to accept that as a ringing endorsement [laughter] of safe injection facilities. We're happy to hear that. We are, of course, awaiting a report, which the City Council funded that we think would be a—a big step forward in establishing the viability, and working out some of the logistical legal questions. What can you tell us about when we can expect this report?

COMMISSIONER BASSETT: So, first let me just add a little bit to the history lesson that you appropriately reminded us of with the Syringe Exchange Programs. There—unfortunately, remain states in the United States, which do not endorse and where syringe exchange is not in place. You may recall that the Vice President was convinced by our

now Surgeon General to permit syringe exchange for the first time in the—when faced with a cluster of—of injection drug use associated with HIV transmission. But anyway, turning to the question that you've asked, as you know, I expect because you I'm sure are aware of the announcements made yesterday the Mayor has—has committed as did the First Lady to a—an April release of the report, and the Administration's response to the report, and the Administrations response to the report.

CHAIRPERSON LEVINE: Well, given that we have a scientifically proven method to prevent fatality and that we have an enlightened Health Commission who seems to acknowledge that science, I think it's imperative that we move forward on this. I understand there are legal complications. I would say let's barrel forward, and if the federal government wants to sue us, we'll take on that fight. That was exactly the challenge we confronted as a society 20 years ago on syringe exchanges. I think the stakes are high enough that we shouldn't let that fear of—of being sued by the federal government stop us from this important effort. I want to turn now to a matter I know you're passionate about, which is

community based public health efforts, which you have really ramped up in select neighborhoods with your Community Health Action Centers, one of which I visited in East Harlem recently. It's—it's clearly an impactful model. We're in three neighborhoods with this kind of full blown multi-purpose public health facility on the ground, which as I mentioned is in East Harlem in Brownsville and also in the South Bronx. This is a big city and there are many neighborhoods with large numbers of low-income residents, communities of color, which don't have such a facility. I identified three, which is Jamaica, the—the Rockaway's Peninsula, and the North Shore of Staten Island. There are I believe at least in Jamaica and the North Shore vacant public health—former district public health offices that were built decades ago and have since been closed that would offer a great location. Do you have plans to expand this model to other needy neighborhoods? Could these shuttered facilities be the place to do it, and what would it cost to move forward on these communities?

COMMISSIONER BASSETT: Thank you for highlighting the importance of community based public health. There are three neighborhoods in which the

Health Department began first with what we called District Public Health offices, and now we call Neighborhood Health Action Centers are the communities in our city that have the highest disease burden. We examined this when I became Commissioner because I wanted to make sure that we were focusing our efforts in the areas where the disease burden highest using as metric premature mortality. That's death before the age of 65. These remain the highest priority areas. To answer specifically your question, we have what we call Neighborhood Health Action Center buildings that have been spruced up, and had some additional investments in both the building and in staff, and the dollar figure on that is about a million dollars per building.

CHAIRPERSON LEVINE: Right. Look, in the context of an $86 billion budget that is less than rounding error. I think the Public Health benefits of investing a million dollars in one of these communities would far exceed the expense. Everyone loves to site Mayor LaGuardia as a progressive hero. He opened 30 of these offices, and it--

COMMISSIONER BASSETT: [interposing] He built only 14, though. [laughs]

CHAIRPERSON LEVINE: What's that?

COMMISSIONER BASSETT: He only was able to build 14. The big—the depression intervened, but yes he opened—he identified 30 health districts in the city, and

CHAIRPERSON LEVINE: Right.

COMMISSIONER BASSETT: --it was prescient strategy.

CHAIRPERSON LEVINE: Well, maybe it was Mayor—Mayor—Mayor Wagner who was the progressive hero in this case. I don't know who finished the project, but I believe that there are 12 now that are not in use for public health purposes. There are some great example. For example, the new Chelsea facility, which if you read the writing on the door it says District Health Office. So, we know the origin of that, but it just doesn't seem to make sense to leave these buildings shuttered in neighborhoods, which today are facing inequitable health outcomes that we don't do more to meet their needs on the ground. I want to acknowledge we've been joined by another stalwart committee member Keith Powers from Manhattan. Thank you. This is a day of multiple simultaneous hearings. So, you'll have to excuse my

colleagues who are running in and out. I want to ask you about food and diet at a time when if you look at the diseases which are topping the charts of leading causes of death in New York City, heart disease, diabetes, hypertension. They are directly related to diet in a way, and I—I think this is more true today than it was in decades past. Maybe you can confirm that, but it's certainly unavoidable that unless we tackle diet amongst New Yorkers we are never going to be able to completely beat these diseases, and one of the main culprits is sugar, and one of the main culprits for excessive sugar intake is sugary drinks. Say what you will about the Bloomberg Era, they were aggressive in tackling sugar intake. In some cases unsuccessfully because of political and legal challenges, but in the meantime, this problem hasn't gone away, and the intake of sugar or soda, which unfortunately disproportionately affects low-income communities and communities of color remains a persistent challenge. So, what is the department's strategy for more aggressively tackling this challenge?

COMMISSIONER BASSETT: Thank you for that question. Your summation is correct. A large share

of our current disease burden is chronic disease that comprises we estimate about 80% of the cause of death and what some people have referred to as the real underlying causes of death, they're not heart disease and cancer and diabetes, but unhealthy food and lack of physical activity. So, I agree with your framing of this issue. In public health we take a prevention approach, and a lot of our work regarding these diseases has focused on diet. As you're aware, the Mayor supported and we continue to—to fight for the idea of calorie posting. We were ready to extend calorie posting to supermarkets where they serve prepared foods when much to our surprise I'll say it surprised me the FDA, the Food and Drug Administration, whose rules these were declared just days before implementation that they wanted to defer it for another year. When we said we were ready, they showed up in court to side with industry, and to challenge the city threatening preemption. We are waiting for these to into effect in May. So, we've been pushing for the policy strategies that have long—long been an important part of our approach to health food. We also continue our work with neighborhood stores trying to improve the offerings

in neighborhood stores, and there are lots of strategies that I was never aware of until we started working this area that make people more likely to buy healthy foods putting water at eye level, healthy snacks at the check-out counter, put fruit and in sight when you enter one of the neighborhood stores. So, we work with small business owners to do this work. Additionally, we had succeeded in putting labels of high sodium, which is an important risk factor for high blood pressure, on the menus and menu boards of the food service establishment that we regulate in the city. But as you point out, we did a have loss with our efforts and the previous administration to limit the serving size of sugary beverages, and Board of Health is following a decision made in June of 2014 is really effectively barred from work in this area. It has been deferred to the legislative area, and we have seen no legislation.

CHAIRPERSON LEVINE: Right, but are you considering new strategies, the kinds that have—that have been considered and rejected, limitations on--

COMMISSIONER BASSETT: Yes, we are in discussions.

CHAIRPERSON LEVINE: Great.

COMMISSIONER BASSETT: This is an important issue and additionally our data as you're aware show that the kind of—the associated benefit of all of the uproar around what people improperly refer to as the soda ban was associated with a steeper decline in reported soda consumption. A sugary beverage consumption has leveled off. Our study in children showed that 50% of—of black and Latino children drink a soda or sugary beverage once a day.

CHAIRPERSON LEVINE: So—so—so--

COMMISSIONER BASSETT: [interposing] So, we are concerned about this issue and we are--

CHAIRPERSON LEVINE: As—as always. So, but are you considering portion control, limitations on labeling and signage or other strategies?

COUNCIL MEMBER BASSETT: Well, the—what remains—we're exploring the options that remain open to us. Portion control does not remain open to the Board of Health, but warning labels have. That's how we succeeded with the—with the sodium warning labels. That's a possibility.

CHAIRPERSON LEVINE: Okay. I'm going to pass it off to my colleague Keith Powers who has a question I believe.

COUNCIL MEMBER POWERS: Thank you, yeah. Thanks. Thank you. I'm sorry I missed your testimony but I'm catching up, and it looks like we covered a lot, and looks like our chair did a great job covering a lot of territory. I wanted to kind of continue, just a couple questions on the food, the food and health, nutrition aspect of it, which is I think the chair got the crux of my question, but is there any legislation that the Department of Health is seeking related to whether it's portion control. I think—because I think your point that the Board of Health doesn't have that jurisdiction, but the City Council may, and—and maybe—and you can correct me if I'm wrong, but is there any legislation that you are seeking or requesting.

COMMISSIONER BASSETT: No, there is—not at this time.

COUNCIL MEMBER POWERS: At this time, and you could--

COMMISSIONER BASSETT: [interposing] But I appreciate your flagging an important public health issue.

COUNCIL MEMBER POWERS: And why not—and just a basic question. It sounds like you might support the concept, but is there a reason you're not looking at a legislative solution for it.

COMMISSIONER BASSETT: Well, to be honest, the—my favorite strategy here would be a soda tax, which has been taken up in many other jurisdictions, but as you are aware, that is something that our governor has been unwilling to entertain.

COUNCIL MEMBER POWERS: And what amount of a tax do you think is effective?

COMMISSIONER BASSETT: Other jurisdictions have used a penny an ounce or two pennies an ounce.

COUNCIL MEMBER POWERS: So, 20 cents on a 20 cent soda, and that—is that—so that discourages consumption?

COMMISSIONER BASSETT: Yes.

COUNCIL MEMBER POWERS: Yeah, interesting. What states or cities have that currently?

COMMISSIONER BASSETT: I don't believe any states have done it, but jurisdictions include several in California including Berkley, San Francisco, the city of Philadelphia has the soda tax. It was one of the bright spots of the election to be honest that several other jurisdictions passed. I don't know what they call it. When the public votes directly for something and—and adopted soda taxes. I think Boulder, Colorado. We can get you a list of the jurisdictions.

COUNCIL MEMBER POWERS: Got it.

COMMISSIONER BASSETT: There are now several.

COUNCIL MEMBER POWERS: And—and, you know, often here in the City Council where—where we—we sort of comment on the loss of power or responsibility to Albany and the inability to get things done because of, you know, of—of sort multi-party politics in Albany and—and the dynamic up there, but I do think there are things at the city level that we should look on all—across the board to

not have to always look at Albany as our solution and then say we don't have support there. Perhaps just a comment is we could work something as much as possible down here whether it's—it's increased warnings in education, or it's—it's actually looking at more ways to control, and I would go beyond sugar. Maybe it's salt and maybe it's other—other areas as well. Are there other—any other areas outside of sugary beverages that we just touched on that the department is concerned about in terms of nutrition and portion control?

COMMISSIONER BASSETT: The—the main one really is the—the problem of added sugar, and we welcome the openness of this committee, and the Council more generally to have conversations about this issue. We'd be happy. I'd be happy to continue the conversation.

COUNCIL MEMBER POWERS: Great. Thank you, and I wanted to switch to—to the flu because I know this is particularly a year where a lot of people were—were getting the flu, and I know—I think access to the shot or—or—or just going out and getting itself still remains I think—I assume below where—where the department and the city would like to

see it. Can you give us any updates on efforts at the city level either both public and private to increase the access to the flu shot, and—and particularly this year any extra steps that were taken?

COMMISSIONER BASSETT: Sure. Just as you point out, this year was a—a bad year in terms of circulating flu. It wasn't a pandemic year, but it was just high levels of usual flu, and it was a bad—a bad strain of the flu. H3N2 is one that's—that the vaccine it typically is not that effective against although it turned out that it was about 36% effective. Many of you may have heard the press talking about under 20%, 19% or 17%. Anyway, it turned out it was more effective than that. A key—a key place to get the flu shot in local pharmacies and pharmacies where really have increased our—our—our proportion of the population that gets flu shots. We were pleased that the Governor issued an order that children over the age of two could get their shots. The cut point before was that you had to be 18 or older. We have supported that and advocated for it in Albany for a long time, and I'm pleased that the state is going to go forward with legislation for

that. In addition, as you probably are aware, the Administration worked to make more flu shots available at no cost. We had a private/public partnership with one of the big pharmacy chains and made a thousand vaccines available in communities—focusing on communities where we have particular concerns. We also worked to promote school vaccines in our school based health centers, which—which we have nearly 160 across the school system, and we, you know, did see an uptick—in the uptake of flu vaccines related to the circulating news that we were facing a bad flue season.

COUNCIL MEMBER POWERS: I got it and—and the—the—the order you referred to is from the Governor and it's--

COMMISSIONER BASSETT: That was from the governor.

COUNCIL MEMBER POWERS:[interposing] That was like an executive order to allow younger--

COMMISSIONER BASSETT: [interposing] Allow pharmacies to immunize younger children—and—and, in fact, most of them weren't that interested in immunizing two-year-olds. I don't think anybody

wants to have a screaming toddler in my store. So, in—in practice it was children the age of 7 and 8.

COUNCIL MEMBER POWERS: That would be, how old I guess?

COMMISSIONER BASSETT: 7 and 8 younger, kids able to, you know, roll up their sleeve and take a shot. [laughs]

COUNCIL MEMBER POWERS: Got it, and this is--?

COMMISSIONER BASSETT: [interposing] So, this—this was a good thing, and we're glad that the- that the Governor has proposed that it be made permanent

COUNCIL MEMBER POWERS: Got it. Are there other vaccinations that the city would like to see where local--

COMMISSIONER BASSETT: [interposing] Yes.

COUNCIL MEMBER POWERS: --can provide a vaccination that aren't currently alike. Because I assume—I mean my position here is like that's an—that is a critical access point for a lot of people, and we shouldn't have to go to Albany every time to do it, but are there other vaccinations that the city has, and I—I recall the city doesn't have authority

on a lot of vaccinations or the local pharmacist doesn't have a lot of it?

COMMISSIONER BASSETT: Well, it would have to be the state that would make this, but we—we would like to see pharmacies with a larger portfolio of vaccines that they could make available to—to adults and children.

COUNCIL MEMBER POWERS: Which—and which vaccine—which vaccine?

COMMISSIONER BASSETT: I could get you the list or I could ask if one of my deputies could give it to you today, but I'd be happy to give you that list, but that remains under the authority of the State Health Department. As you may be aware, we are still in court defending our—our—our desire to make certain vaccine requirements mandatory in daycare centers. So, we've been challenged by the state on this, and we're in the court defending it. I don't know if our—Is our General Counsel here? No, our General Counsel is not here. So, I really am—can't tell you more about the details of that case, but we continue to litigate the right of the city to determine vaccination requirements in our city regulated childcare centers, but we have been

challenged. We wanted to make it a requirement where children get flu shots.

COUNCIL MEMBER POWERS: Great. Thank you. Thank you, Chair.

CHAIRPERSON LEVINE: Thank you, Council Member Powers. I understand that on a citywide basis we had adequate supplies of vaccine testing and Tamiflu, but there were definitely localized shortages. I myself when I came down with the flu, my doctor's office didn't have any testing kits. So, I was prescribed Tamiflu based on the intuition of the—of the doctor.

COUNCIL MEMBER BARRON: [off mic] Where you got the med if I may ask, Council Member.

CHAIRPERSON LEVINE: Yes, you may and—and I—I would be--[laughter] I would have to resign my chairmanship if I didn't tell you. [laughter] Yes, I was. Next year maybe you can administer the shot so there's no ambiguity, and I will say that I recovered in two days, which I'm attributing to having been vaccinated. One of the benefits, of course, as you know, is a quicker recovery. So, but—but we've heard certainly anecdotal reports of—of lack of availability of testing of Tamiflu and I

think even in some cases of particularly I think pediatric vaccination. So, how do we grapple with this problem where the city on the whole has a supply, but clearly not every provider does?

COMMISSIONER BASSETT: As you point out, contrary to previous years where we have had shortages in this past season, which actually remains ongoing although it's clearly on the downturn, we have had no shortages of either vaccine or Tamiflu. So, the problem is simply one of projected demand, and because we had a worst than usual flu season, the demand for the vaccine rose, and not all facilities were equipped for the increased demand. It sounds like the place that you went to wasn't. So, they should have been able to replenish their stocks and—and make it—make it available. The shortage of testing I'm—I'm not a sure about. So, I would have to get back to you on that, but I'm positive that we had no shortage of either Tamiflu or the vaccine and I've been joined by the Deputy Commissioner for Disease Control. Dr. Daskalakis, if you could introduce yourself and be sworn for the committee and perhaps you can tell us about the problems that the Chair has mentioned regarding testing.

CHAIRPERSON LEVINE: Well congratulations. Thank you guys.

DEPUTY COMMISSIONER DASKALAKIS: Yeah, Deputy Commission for Disease Control.

LEGAL COUNSEL: Do you affirm to tell the truth, the whole truth and nothing but the truth in your testimony before this committee and to respond honestly to Council Member questions?

DEPUTY COMMISSIONER DASKALAKIS: I do affirm. So, specifically on the issue of testing kit availability, we—we did not detect any abnormalities in terms of availability of kits in terms of supply side. There are generally spot shortages because a clinic, a doctor's office won't order enough. So, what isn't there one day, will be the next day, but an important note, your doctor did the right thing. So, the rapid influenza test is really good at confirmation influenza. If you have influenza symptoms and that test were negative, you would probably still need to get Tamiflu. So, in other words it's nice to have that information, but clinical suspicion is enough to move, and thankfully there was no supply problem with Tamiflu. Again, some pharmacies did have spot shortages. So, one day

they wouldn't have it, but when they ordered it, it would arrive.

CHAIRPERSON LEVINE: And how do we tackle the persistent inequity in the rates of vaccination. If I have my numbers correct, I believe that for white New Yorkers it's 69% and for African-American New Yorkers it's 50%.

COMMISSIONER BASSETT: Yes, that is correct. This has been a protracted problem. We continue to do outreach to communities which have historically under—underutilized vaccine for flu, and we'll just keep working at it by—through education and outreach. I just want to use this as an opportunity to remind everybody that we want people to start getting their flu shots in September so that they've been immunized in advance of flu season, which typically begins in October, and it's still not too late to get a flu shot. The flu season runs through May.

CHAIRPERSON LEVINE: Well, given that we're having a Nor'easter tomorrow, I think people understand that the winter and the flu season are not over yet. On the topic of family planning, incredibly the Trump Administration, as I alluded to

in my opening remarks, is redefining the parameters for funding in this area. They—we're currently getting $5 million in federal funding for our Bureau of Sexually Transmitted Disease Control, and the Trump Administration's application for family planning funding now emphasizes abstinence, and nature family planning. That has got to be the euphemism of the year. I had to dig around and I found out that they were referring to the rhythm method with that term. So, do we—are we even going to reapply under—under such restrictions for that $5 million, and if not, how are going to –how are we going to maintain those services?

COMMISSIONER BASSETT: Well, we're certainly committed to maintaining access to contraception in the city. We valued our collaboration with Planned Parenthood of New York over the years, and we as you're aware also offer contraception at our sexual health clinics. We'll just have to look at this. This is what they're proposing, and make a determination. We certainly are intent to seek every federal dollar that we can use for our programming.

CHAIRPERSON LEVINE: Okay. So not everyone knows that inspection of childcare facilities is under your auspices. We have dramatically expanded the number Pre-K programs in this city, and now adding 3K. That's great news. Most—most or at least many of those programs are not in public school buildings, and they are in a hodgepodge of settings from basements to storefronts to converted apartments, and so we have to have inspectors in there to make sure that they're safe, that they're not exposed radiators or windows that it's easy for a little kid to fall out of. Perhaps even lead paint is part of that process. I don't know, but we need—we need professionals in there to make sure that this is safe for a 4-year-old or a 3-year-old. If I'm not mistaken, the number of safety inspectors has not risen in proportion to the growth of the number of programs. You call this title I think Early Childhood Education Consultant. ECEC I know is the acronym, I—I believe that you've had a hard time attracting and retaining and perhaps there are not enough budget lines. Can you tell us have we maintained the proportion of inspectors to programs as we've grown this system throughout the city?

COMMISSIONER BASSETT: Well, that's a really good question, and the—you are correct. The childcare program is responsible for the inspection permitting and licensing on behalf of the state of—but of our—both our childcare centers, which are regulated by the city and family, and good family daycare, which are under state jurisdiction, but we regulate on their behalf. I'm—there are two parts of the way we look at childcare. One is the—what you mentioned about the physical environment and its safety and it meets fire code, building code, and—and our safety requirements, and then we are concerned that the people working in childcare are appropriately trained professionals, that there's an educational director for the child care center so that the content of the experience is—is provided by appropriately trained people. It's that latter part that is he usual—is the usual responsibility of the ECECs, the Early Childhood Educational Consultants, and our inspectors are the ones who go to make sure that the number of children meets the license that they're the right number of staff, and that the-and the physical environment is appropriate.

CHAIRPERSON LEVINE: [interposing] But, and—and—

COMMISSIONER BASSETT: So, we greatly—have greatly bolstered our inspection program, and couple of years ago increased the number of inspectors. To my knowledge, we are able to meet the requirements of—of-of inspections that the current portfolio demands.

CHAIRPERSON LEVINE: And do you know how many inspectors we have today, and what that number would have been before the growth of Free Start?

COMMISSIONER BASSETT: I don't. I don't, but I—I know that we have about 2,300 childcare centers, and I don't know how many people we have or how many vacancies that we have. If my Deputy Commissioner has that information, I can ask her to—to provide it.

DEPUTY COMMISSIONER ANGEL: We'll get back to you with the exact numbers, but I will say that as the—with the roll out of UPK, we were—we have expanded and we have adequate staff to inspect both for the health and safety requirements, which the Public Health Sanitarians conduct those inspections

and the educational consultant inspections, which are for regarding qualifications and—and clearances.

CHAIRPERSON LEVINE: Well, we—we hear reports of rising workloads for the ECECs and very attrition rates, which makes me concerned that we're not getting every childcare facility in time, but you can assures us that's not the case?

DEPUTY COMMISSIONER ANGEL: We are—we are reaching all of those childcare sites and, in fact, we have—we're just increasing the ECEC staff to be able to make sure that we reach that target.

CHAIRPERSON LEVINE: Okay. Well, I am pleased that we have been joined by my predecessor as chair of the Health Committee who's left me impossibly big shoes to fill, and obviously our Speaker Corey Johnson. I'm going to pass it over to him.

SPEAKER JOHNSON: I only wanted to come by because I was leaving the other hearing, and I saw that this hearing was going on to tell you that you're in very good hands as you know already with Chair Levine, and I have really a soft spot in my heart for, of course, the New York City Department of Health and Mental Hygiene, and the critical work that

you all do everyday, and Dr. Bassett it was wonderful to work with as Health Chair, and we're going to continue to work together, but, you know, Chair Levine I think is the perfect person to succeed me on the critical work that the Health Department, and the Council I think in the past when I was chair, but also not just amongst me, but other members. I really tried to champion public health measured that mattered and pushed for more dollars when sometimes you weren't able to fully say you needed more dollars, we were the ones banging the drums for more dollars, and I know that Chair Levine we had a great event at the Chelsea STD Clinic the other day, which he came to. And I just wanted to come by, and say that I still, of course, support the mission and work that you all do every single day, but also you're in great hands with Mark who has been dedicated to these issues for years. And—and he and I are going to work together on ways to continue to ensure that the best public health department in the United States of America gets the support that it needs. So, I have no questions, just a statement of affection and support for both you and for Chair Levine. So, I wanted to come by when I walked by the door and heard

that mellifluous voice testifying, I wanted to come by. So, good to see you, Mary.

COMMISSIONER BASSETT: Thank you, Speaker Johnson. Much appreciated.

SPEAKER JOHNSON: Thank you for letting me interrupt to provide my support and affection, Chair Levine. [laughter]

CHAIRPERSON LEVINE: You see how nice we are in the City Council?

COMMISSIONER BASSETT: So, I did want Council [off mic]-

CHAIRPERSON LEVINE: Thank, thank, thank her? [laughter]

SPEAKER JOHNSON: I know you had a lot of hearings.

COMMISSIONER BASSETT: [interposing] I know you had a lot of hearings, too--

CHAIRPERSON LEVINE: [interposing] Thank you, Mr. Chair.

COMMISSIONER BASSETT: But I did want to say that—

CHAIRPERSON LEVINE: [interposing] Okay.

COMMISSIONER BASSETT: --make sure that you're aware of something that we started in—in my

tenure in environmental health as a childcare program is a—is a more focused attention on low performing centers where—so that we identify places where they- they are not closed. We very rarely have to close a childcare site, but they are sort of low performing more than one inspection to put them into a kind of performance improvement track to work directly with them to try to make sure that they don't just pass, but that they are the kind of center that we would all want to send our kids to.

CHAIRPERSON LEVINE: Alright. I'm going to—I want to close on—on a topic that I alluded to earlier on, which is the imperative that we find a way to connect undocumented New Yorkers to healthcare services. We have thankfully a comprehensive program in Child Health Plus, which is reaching most undocumented kids. So, we talked—when I talked about this challenge referring to adults, but the numbers there are still quite significant, estimated to be 300,000 undocumented adults in the five boroughs who are not eligible for any of the healthcare—health insurance programs that we've been speaking about. We had a groundbreaking pilot here over the last year or two called Action Health, which connected over

1,000 undocumented New Yorkers to primary care services and it's been evaluated, and I would like to know whether you consider that program to have been a success, and if so, then will we continue it?

COMMISSIONER BASSETT: Well, thank you for that question, and as you know, we are very concerned about the access to care for the undocumented. We want everyone to know that almost all children are entitled to be covered including undocumented children under Childcare Plus, Child Health Plus, and that's part of the educational outreach. The Action Health NYC Program that you allude to was concluded in June of 2017 at the end of the last—the last fiscal year, and we have made the report available to you. As you know, we were able to recruit I believe it was 1,300 people who received the full Action Health service, which in return for committing to get their care at one of seven-nine primary care sites around the city, they got case management and—and enhanced continuity of care, and their referral to—specialty was in the Health and Hospital system. So, we—we compared to people who go usual care, and it was promising and we shared those findings with not just you, but with the Health and

Hospitals, which is the—the healthcare system in our city that we're so lucky to have that provides care to everybody who walks in the door regardless of their status or their ability to pay. So, I'm—I expect that they will take this experience under advisement and continue to work on it. As you know, the current--

CHAIRPERSON LEVINE: [interposing] They being the public hospitals?

COMMISSIONER BASSETT: Yes, the public hospitals.

CHAIRPERSON LEVINE: But the Health Department could fund this program in the future, no?

COMMISSIONER BASSETT: The—the program came to an end. It was funded, as you're aware by philanthropic dollars, and it ended in June of 2017. It's the lessons from this program that I think will guide the renewed commitment to primary care in the Health and Hospitals.

CHAIRPERSON LEVINE: But given the success and understanding those private dollars, and therefore, limited, is the city considering a public investment and expanding and—and making permanent such services?

COMMISSIONER BASSETT: The city has shown and enormous commitment to the public hospital system, which remains the main resource for New Yorkers who need care, who can get that care regardless of their documentation status, or their ability to pay.

CHAIRPERSON LEVINE: Well, I—I am grateful that we live in a city where anyone can go into an emergency room and receive medical care, but as you know, primary care is an incredibly powerful vehicle for preventing disease, from managing disease, and it really yields tremendous health benefits, and also again financial benefits because it's much cheaper to address the condition early or even to prevent it before the onset in the setting of a primary care facility than it is to treat someone who's coming into an emergency room, which is where people land that have no alternatives. So, I believe it's essential that we find a way to connect every single New Yorker--I don't care what their documentation status is--to primary care services for their benefit and for the financial benefit of the broader health system so--

COMMISSIONER BASSETT: I'm—I'm sure that you're aware that the new president and CEO of Health and Hospitals, Mitch Katz is—has expressed a clear commitment.

CHAIRPERSON LEVINE: [interposing] He—he agrees—he agrees?

COMMISSIONER BASSETT: He agrees.

CHAIRPERSON LEVINE: Alright. Well, we're going to close out our section of the hearing today. Thank you very much, Commissioner Dr. Bassett. Thank you.

COMMISSIONER BASSETT: Thank you, Chairman Levine.

CHAIRPERSON LEVINE: So, we're going to ask the Chief Medical Examiner to join us. [background comments, pause]

CHAIRPERSON LEVINE: Okay, welcome Dr. Sampson.

DR. SAMPSON: Thank you.

CHAIRPERSON LEVINE: I'm excited for round two of our hearing in which we will be reviewing the New York City Office of the Chief Medical Examiner, and the $78 million Fiscal 2019 Operating Budget. We will also be addressing the

offices' performance indicators from the Fiscal 18 Preliminary Mayor's Management Report and the $55 million in OCME capital projects in the Fiscal 2019 Preliminary Capital Budget and Commitment Plan for Fiscal 2018 to 2022. The work of your office is largely unseen by New Yorkers, and—and probably unappreciated or underappreciated. I suppose TV shows like CSI have perhaps partially remedied that, but the truth is that your work really is essential to maintaining public health in this city and also it's a pillar or the Criminal Justice System, and your mandate has really grown in recent years with expansive—expansion of the use of DNA testing with the rise of the opioid crisis, and also in the Post-911 era the degree to which we have to prepare for mass death events. It's no longer a hypothetical in this city. So, you are certainly doing more than ever before, and we're looking to dive into that work and the question of whether you have adequate resources for that. Among other topics, we're going to be looking in the hearing about lead time that you are taking for completion of DNA cases for various types of crimes. The lead time today I believe stands at 39 days for homicide cases, at 41 days for

sexual assault cases, and a whopping 164 cases for property crimes. I believe that we can and should do better to reduce the lead time in all those categories understanding that we particularly have to prioritize violent crimes, homicide and sexual assault, but that even property crimes need to be taken seriously. Similarly, we'll examine the lead time required for scene arrivals from medical, legal investigators, MLIs. I believe that time stands at 1.7 hours in the first four months of Fiscal Year 2018. I believe that may in part be due to understaffing of the MLI position. We'll give you a chance to address that. Retention rates I believe for MLIs appear to be low, which I think may be part of an office wide challenge faced by other titles as well. And finally, although in the Fiscal 2019 Preliminary Capital Budget and Capital Plan there is new funding included for OCME capital projects. I look forward to receiving an update on those projects and whether the funding is adequate address the needs of—of what I can say based on a first hand view, significant outdated facilities that you have, some of which date to the 1950s. I want to thank, as always, my great committee staff and Janette Merrill,

Crystal Pond and Zeina Emmanuel Helou (sp?) for their hard work in preparing for this hearing, and I'm pleased that we remain in the presence of committee member Keith Powers, and I'm now going to turn it over to our committee counsel to administer the affirmation to the Administration.

LEGAL COUNSEL: Do you affirm to tell the truth, the whole truth and nothing but the truth in your testimony before this committee, and to respond honestly to Council Member questions?

DR. SAMPSON: I do.

CHAIRPERSON LEVINE: Okay, Chief, take it away.

DR. SAMPSON: Thank you. Good morning, Chairman Levine and members of the Health Committee. Thank you for the opportunity to testify here today. We at the Office of Chief Medical Examiner value your leadership, and thank the City Council for its support in 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 humanly possible. Seated with me are Dina Maniotis, Executive Deputy Commissioner for Administration, and Florence Hutner, my General Counsel. I start my fifth year as the appointed Chief of the strongest and most comprehensive medical examiner office in the country. Together, we celebrate with all New York City the centennial of this office, which is the home of the first U.S. forensic toxicology laboratory. Let me begin with the tremendous accomplishments of our Toxicology Laboratory. That lab has in the last two years undergone an expansive reorganization and strengthening through staff training, and the acquisition of advanced analytical instrumentation. The result is that a backlog of more than 800 cases was eliminated in less than three months in 2016, and turnaround times for completion of case work have been drastically reduced from an average of 120 days to 20 days or less with over 90% of all cases completed within 30 days. This is twice as fast as the national standard. Further, the tox lab maintains both New York State and the American Board

of Forensic Toxicology accreditation, expanded the scope of its testing and developed new testing methods to address the changing needs of modern forensic toxicology laboratory. All of this was achieved during a particularly challenging time, the ongoing nationwide opioid epidemic. The OCME investigates all deaths, which may in any way involve drug intoxication, and we perform autopsies and forensic toxicology testing to determine the cause and manner of death of these individuals. The New York City Medical Examiners play a central role in helping to characterize the opioid epidemic serving as a critical source of data regarding which drugs and which drug combinations are causing these deaths, and which populations may be at greatest risk for fatal overdoses. As part of HealingNYC, the Mayor and First Lady's plan to disrupt the opioid epidemic in New City, the OCME routinely sits at the table with law enforcement and public health partners across all levels of government to analyze this epidemic and formulate strategies to combat its impact. As part of these investments made through HealingNYC, the lab introduced a new method capable of screening 30 different synthetic opioids, an

essential tool to meet the challenge of the opioid epidemic, which is fueled by illicit Fentanyl. The in-house tools allow OCME to share its findings with our partner agencies in real time at an unprecedented level of detail helping inform decisions made by DOHMH and law enforcement. Our lab continues to develop advanced methodologies to identify emerging illicit drugs including not only synthetic opioids, but also other novel psychoactive substances. These designer drugs are increase in prevalence, and the laboratory will continue to ensure it is equipped to deal with constant changes in drugs available on the street, and to support the medical examiners in determining cause and manner of death. The Toxicology Lab also has the technical expertise and advanced laboratory instrumentation to provide the city of New York with a centralized forensic toxicology service. In September 2017 with the support of the New York City District Attorney's Offices and the NYPD, the OCME Forensic Toxicology Laboratory was approved to test all specimens collected in New York City from individuals suspected of driving under the influence of alcohol or drugs. Previously, some of those tests were performed by the

NYPD Lab or by a private laboratory. Having a centralized service at OCME to perform this work saves on substantial costs associated with having tests carried out by private labs, and from bringing those experts from out of state to testify in New York City. In addition, all DUI cases will be tested for both alcohol and drugs. Further, our laboratory with significant investment over the past two years in staff training now has the greatest number of New York State certified analysts for alcohol testing anywhere in the country. We have the capacity to provide expert witness testimony across all five boroughs of the city. Through new funding, two staff are being on-boarded to support the additional casework received in DUI—for DUI testing. These include a criminalist who will carry out the laboratory duties, and a laboratory inventory manager who will manage the consumables required to deliver this service, return completed evidence to NYPD, and provide additional laboratory support duties. Since 2017, we have seen a threefold increase in the number of DUI cases submitted for testing, but nevertheless, have continued to maintain turnaround times of less than 20 days. The increase has not impacted our

ability to complete cases submitted by medical examiners or cases submitted for testing for suspected drug facilitated sexual assaults. At the end of 2017, mean turnaround times were 17 and 18 days respectively for these cases. In addition, to the American Board of Forensic Toxicology accredited Tox Lab, OCME is also the home of two other highly advanced accredited labs, the Forensic Biology Lab and Molecular Genetics. So, now I will turn to the Forensic Biology Lab. The OCME operates America's largest public forensic DNA Laboratory, and is a leader in DNA technology and research. Forensic biology also processes environmentally challenged and degraded skeletal remains utilizing optimized bone extraction techniques. We are also continuing to work on the unidentified remains of the 9/11 terrorist attacks. This August we identified the 1,641st person from the attack on September 11th. We honored the wishes of that family to withhold the name of the person identified. The identification of this victim was performed by our laboratory using new technologies developed in-house and placed online in 2017. This year we have also re-associated many remains to previously identified victims. As we

promised the impact families in 2001, we are continuing our work on the identification of the victims of this disaster. Since 2015, the Forensic Biology Lab has experienced a record increase in case submissions all while maintaining an excellent turnaround time of approximately six weeks for crimes against persons. In Calendar Year 2016, the laboratory experience a profound 46% increase in cases over 2015. The increased case submissions are continuing. Most of this increase is due to the process of gun crimes resulting from the successful mayoral initiative called Project Fast Track. Forensic biology added new needs funding in July 2017 and increased capacity to hire 53 staff to address case submission increases of which 35 are forensic molecular biologists and 18 are operations staff. We have been successful in our effort to recruit, onboard and begin intensive training of the staff. Additionally, we have been successful in training and promoting our very capable current employees into positions of great responsibility and complexity. In January 2018, the fourth refinement of our production system using efficiency practices of Lean and Six Sigma was implemented to essentially do more with

less, process more cases than can be achieved by new hires alone. Initial results are very promising. Our goal is to continue to reduce our backlog and turnaround times even with a dramatic increase in cases. Our Preeminent Molecular Genetics Laboratory directly supports our mandate to investigate sudden unexpected and unexplained deaths in apparently healthy New York City residents. Advances in molecular medicine have increased the ability to identify diseases at the molecular level that escaped discovery after completed autopsy, microscopic examination and toxicology testing. Currently, the lab performs molecular analysis of 95 cardiomyopathy genes, those are diseases of the heart; thrombophilia molecular testing. Those are diseases that cause clotting, and sickle cell disease. The 95 cardiac gene test panel has nearly tripled the success rate of the six gene panel it replaced. The Molecular Genetics Laboratory received its third consecutive zero deficiency, which means a perfect score during its College of American Pathologists biannual announced—unannounced onsite inspection. Since 2016, we have also been providing professional genetic counseling services and support to families of the

decedents who test positive by our laboratory. Finally, two articles on molecular diagnostics in in idiopathic pulmonary embolisms and sudden unexplained deaths have been accepted for publication in highly respected peer review journals. In 2015, at my direction the agency conducted an in-depth analysis of the mortuary units operations, which resulted in a series of corrective actions to meet an ambitious standard of 100% accuracy 100% of the time. The City Council funded OCME in FY16 with additional mortuary staff and since then I am proud to say we have built a truly outstanding cadre of forensic quality specialists who work tirelessly to ensure the highest quality control in mortuary operations. Even with added controls that are by their nature time consuming, we have maintained excellent processing times for our stakeholders. In 2017, funeral directors waited only 31 minutes on average to pick up a decedent. Overall, in 2017 and across the boroughs, OCME made remains available or ready to release for burial in 1.7 days. Remains are picked up by funeral directors on average about eight days from when they are ready to release. I want to turn now to the Preliminary Budget. The New York City

OCME has approximately 740 employees, and an operating budget of $78.4 million of which $76.4 million is city tax audits. In this Preliminary Budget we received 20 new positions to augment our mortuary operations and run two additional medical examiner transport teams 24/7 and 365 days a year. The Tox Lab received two additional staff and $86,000 in OTPS to conduct all of DWI testing for all New York City cases prosecuted by the DA's in all five boroughs. In conclusion, I want to express my gratitude to the city, this administration and this City Council for valuing and supporting OCME and science serving justice. I would also like to publicly thank the family members with whom our staff interacts each day. As I end my 20th year as New York City Medical Examiner, I can speak for all OCME staff when I say that providing answers and a little bit of comfort to grieving families is the greatest reward of our job. I'm happy to take your questions.

CHAIRPERSON LEVINE: Thank you, Chief, and I do want to acknowledge that the scientists in your office and many of the other professionals could make a lot more money elsewhere, and that they've chosen to work with OCME because they believe in the

mission and—and we're grateful for that. I do want to address the question of lead times in the areas that I identified earlier. Excuse me, I also want to pause and acknowledge we've been joined by fellow committee member Inez Barron. Thank you. So, did I have my numbers right on lead times for DNA tests for the various crimes?

DR. SAMPSON: They're—they're turnaround times. Yes.

CHAIRPERSON LEVINE: Turnaround times.

DR. SAMPSON: Average turnaround times. Yes, average turnaround times.

CHAIRPERSON LEVINE: Okay, so it's 39 days for homicide, 41 days for sexual assault, 164 days for property crime.

DR. SAMPSON: That's correct.

CHAIRPERSON LEVINE: Is that right? And how does that compare to prior years, those—those turnaround times?

DR. SAMPSON: They are higher than they were the last few years because of the increased number of case submissions. As you alluded to, we have prioritized crimes against people. So, our turnaround time for homicide cases and for sexual

assaults cases is low. We have no backlog at all in any of those cases, and we work very closely with the police and the district attorney's office. So, when there is a—a case that they feel they—is a public—eminent public safety issue, we work with them and are able to rush those cases so that they cases so that the cases can be completed within a few days. So, otherwise the—the cases that we have been forced to deprioritize are those that are—involve property crimes, but the—we've taken a number of steps to begin to address that backlog in particular.

CHAIRPERSON LEVINE: Right, this is just—it's so important because as investigations drag on, it becomes more difficult to apprehend a suspect as you well know, and because if—if someone who has committed a homicide is at large, identifying that person is of utmost importance, and the same is true for someone who commits sexual assault or to a lesser degree, but not—it's not trivial someone who commits a property crime. Am I to understand that you said in a priority case you can turnaround one of these tests in a matter of days?

DR. SAMPSON: Depending on how complex the testing is, we can do it sometimes within 24 or

36 hours. Sometimes it's a little bit more complicated so it takes several days, yes.

CHAIRPERSON LEVINE: Right, so if this—you're not like growing something in a petri dish that has to sit on a shelf--

DR. SAMPSON: [interposing] Right.

CHAIRPERSON LEVINE: --for several weeks, right. So, where there are the resources, you can do this in many if not most cases in a matter of days. Is that correct?

DR. SAMPSON: In a particular case when we prioritize that over other case work. Obviously, if we prioritize one case or a few cases, then other cases don't get done, which increases then the turnaround time for the other cases.

CHAIRPERSON LEVINE: Right, but there's not an ongoing test underway for these 39 days. There's essentially the kit, if that's the term, is sitting on a shelf somewhere, correct?

DR. SAMPSON: Well, if there's—let me—let me correct myself a little bit. That is a few days to the generation of information that is useful for the police and we share that with them in these kinds of cases very quickly. There are other steps after

the completion of the testing that must go on, quality assurance steps, writing the lab report itself, having senior criminalists review those lab reports. These are all parts of our accreditation. So, the final report is not ready within, you know, 24 hours.

CHAIRPERSON LEVINE: But that can be more than a few days to get to the QA.

DR. SAMPSON: [interposing] Oh, no, that actually takes quite awhile because the—the number of people who can do that kind of work, the most senior criminalists, it—it takes time for them they—they have such a great number of cases, it takes time for them to get through them.

CHAIRPERSON LEVINE: Right, but in these expedited cases where the testing period lasts several days, when is the final report done and those that you're expediting?

DR. SAMPSON: They—once we give the information to the police, the final report is not—it—it's not as critically important, but it's probably—I don't know off, but off the top of my head, but you're right, it's not very long after that.

CHAIRPERSON LEVINE: Got it. So, how many staff are currently in the DNA Testing Division. [background comments]

DR. SAMPSON: Yeah, approximate 160.

CHAIRPERSON LEVINE: Okay. Is it not simple math that if we increased your headcount there we could turn around these tests more quickly?

DR. SAMPSON: Yes. So, we have increased our headcount by 53. We were given 53 additional headcount last year, but remember that to onboard a scientist is a long process. We have identified all the scientists of those 53. I think it was about 49- [background comments] 48 total. They are in their training process. So, we have to—before they can do any testing, they have to go through training in our laboratory as required by the FBI. The FBI has got standards for this. So, that training takes at least six months depending on the level. It can take up to a year. So, these scientists now are going through that training, and will join as quickly as possible the actual lab work, but that takes time. We do have—that's why in addition to onboarding new staff, we also have a plan to reorganize the laboratory to increase that efficiency. So, with the plan that we

just started now we are able to address the backlog as well, and we--[background comments]—we anticipate that the backlog in property crime once everything is—all the scientists are—are in the laboratory, we can whittle down over a matter of about 30 months. So, we do have a plan to address the-the entire laboratory.

CHAIRPERSON LEVINE: Alright, I just want to pause here now because we've been joined by the famous red shirts of the AARP. We're glad you're here and hoping we'll get to hear testimony from you in our public section—session. So, you're about to onboard this new cohort. At that point, what can we expect lead times to drop to?

DR. SAMPSON: The—our target is 30 days. That's a very ambitious target, but we've set that purposely.

CHAIRPERSON LEVINE: [interposing] For all categories of crime?

DR. SAMPSON: Ultimately, yes. That's our—our goal is—is 30 days.

CHAIRPERSON LEVINE: Got it. We're going to be monitoring this closely. This is work that we need to invest in. The criminal justice process

depends on, and we'd appreciate it if you would keep us update on this important balance between the staffing resources and the lead time in this category. As for the time it takes to retrieve a deceased person, a job that you rely on the medical—medical legal investigators for in their lives, am I correct that the lead time is—is 1.7 hours currently?

DR. SAMPSON: 1.7 hours for our arrival at the scene, yes.

CHAIRPERSON LEVINE: So, this isn't like an ambulance which has to get there in minutes to save someone who is still living. I don't want to overstate this, but there are also a lot of reasons why you don't want a body sitting around without retrieval. There may even be scientific reasons why you want to retrieve the body quickly. I don't know about that, but there certainly is a public interest in quick retrieval. So, how many MLIs do you currently have on the job?

DR. SAMPSON: We currently have 27 MLIs on staff, and five positions added in the new needs.

CHAIRPERSON LEVINE: Got it. You have 20--

DR. SAMPSON: But those—those—those—I'm sorry. Excuse me. Those five remain vacant.

CHAIRPERSON LEVINE: Those five remain--?

DR. SAMPSON: Right now. So, we have 27 on staff--

CHAIRPERSON LEVINE: Right.

DR. SAMPSON: --and we got five positions added, but those remain vacant.

CHAIRPERSON LEVINE: Because?

DR. SAMPSON: Because of the difficulties in recruiting Medical Legal Investigators. They are trained Physicians' Assistants and the market for Physicians' Assistants is extremely competitive.

CHAIRPERSON LEVINE: Yes, this is—this is a—a—this is a high stakes job. This is more than just transporting an inanimate object. This is dealing with bodies, and so we expect them to be highly trained. So, are we underpaying them? Why are we having trouble recruiting?

DR. SAMPSON: It's—there's just two—the physician's assistants are very popular in the medical field. There's just too many competing jobs in hospitals and other positions--

CHAIRPERSON LEVINE: [interposing] And are--?

DR. SAMPSON: --making our position less attractive.

CHAIRPERSON LEVINE: Are you, therefore, confident that—are we retaining those—those positions that it currently showed, or are we also facing retention problems?

DR. SAMPSON: Our retention percent attrition--

CHAIRPERSON LEVINE: Yes.

DR. SAMPSON: --in FY17 was 15%.

CHAIRPERSON LEVINE: Okay. I'm not sure if that's above or below what you're targeting, but it's certainly worrisome that you have unfilled positions for a critical function. How low could—how much would the lead time drop if you had all your positions filled?

DR. SAMPSON: The—let me address the arrival times. So, that arrival time of 1.7 hours includes all cases where we go to the scene. So there are some cases where purposely delay our arrival at the scene. A good example is in a suspected homicide we have to coordinate our arrival of our investigator

with the crime scene detectives that—that are also responding to the scene. So, and they often have to do part of their work first before we can do our part of the work. So, that's incorporated into that 1.7 hours. Another example of where we purposely delay our arrival at the scene would be in a—if a person dies an apparently natural death, and we are communicating, attempting to communicate with the person's physician to establish where OCME even needs to take jurisdiction. That can also—we—we purposely delay the scene for that reason. What we're most interested in when we discuss arrival times are those cases where a body is in public view.

CHAIRPERSON LEVINE: Right.

DR. SAMPSON: So, for example, you know, somebody tragically is hit by a car in the street. Those kinds of cases we look at separately and those arrivals are shorter than that 1.7.

CHAIRPERSON LEVINE: What is an average arrival time for a public view?

DR. SAMPSON: [interposing] For what—what we've tracking closely for example subway incidents and those have been—the arrival time about a half an hour on average since we've been tracking them.

CHAIRPERSON LEVINE: Well, I'm sorry to—to-to observe that we had a death in the subway system this morning--

DR. SAMPSON: [interposing] A tragic death this morning. I'm sorry.

CHAIRPERSON LEVINE: --at 4:00 a.m. of a track worker. It's just horrible--

DR. SAMPSON: Yes.

CHAIRPERSON LEVINE: --and I assume your office would—would be involved in such a case. Is that correct?

DR. SAMPSON: Yes, we were involved. Absolutely.

CHAIRPERSON LEVINE: Okay, we don't negotiate labor contracts in City Council hearings, but it sure seems to me we've got to pay the MLIs better to attract the talent that we need so that we fully staff this function. I'm going to pause and turn to my colleague Council Member Powers who I believe has some questions.

COUNCIL MEMBER POWERS: Yes. Thank you, and thank you for being here.

DR. SAMPSON: Thank you.

COUNCIL MEMBER POWERS: You're—you're not in my district, but just you're very close, and I walk past your building on I think on 20—26th Street, is that right--

DR. SAMPSON: Yes.

COUNCIL MEMBER POWERS: --often. And actually, just a quick aside before I ask my other questions—are you—what is the long-term plans to stay in that building on 26th Street?

DR. SAMPSON: Uh, but so, we have two buildings right in that area.

COUNCIL MEMBER POWERS: [interposing] Yes.

DR. SAMPSON: The building on 26th Street is a beautiful—our DNA Lab, administrative offices--

COUNCIL MEMBER POWERS: [interposing] Right, right.

DR. SAMPSON: --and we plan to stay there forever, and then the other building that you might being referring to is the--

COUNCIL MEMBER POWERS: [interposing] The old, yeah, that's the one, right.

DR. SAMPSON: --520 First Avenue on 30th Street.

COUNCIL MEMBER POWERS: Right, right, right.

DR. SAMPSON: Right.

COUNCIL MEMBER POWERS: You have plans.

DR. SAMPSON: So, our plans for that as Council Member—Chair Levine alluded to. It's an old building over 50 years old definitely in need of replacement, and we are working very closely with EDC and OMB to establish a place for the new building, and I'll be glad to update you as soon as we have more information about that, but it's going well. It's at the planning stage.

COUNCIL MEMBER POWERS: Just asking. It's my-

DR. SAMPSON: Yep, I appreciate it.

COUNCIL MEMBER POWERS: --it's—it's on my commute. So, I—the—I'm the Chair of the Criminal Justice Committee, and we've gotten some inquiries related to Hart's Island, which I believe is the island where the—people are buried if they're unclaimed by a family member or close, you know, a close person. Can you just give us more information about the relationship between your agency and the Department of Corrections related to Hart's Island?

DR. SAMPSON: Certainly. Right, so the people who go to City Cemetery are exactly as you described, either people who are unclaimed or whose families have chosen them to go there, or they are unidentified. Our role is we do a complete process to try to identify each and every person before they are sent to city burial. So, just to give—put it in perspective there, we handle about 10,000 decedents every year. About 1,000 of those on average go to city burial. This last year in 2017, only 23 of those were unidentified. So, we—you can imagine the challenge of identifying someone where you really have not much to go on. So, have a—a very extensive process to do this. Before any individual is transported to City Cemetery, the Outreach Unit conducts extensive investigation to identify next of kin. They go-if the person came from a healthcare facility, we reach out to the healthcare facility to see if there is any next of kin, and we also determine if there's any plans for final disposition of the decedent. We contact the public administrator in the relevant borough as well as two New York City organizations that hold information about pre-paid funeral plans. The Outreach Unit also conducts an

Internet investigation including sites such as the National Mission and Unidentified Persons System called NamUs (sp?), and HHF's databases. If a decedent is determined to be a veteran without known or interested next of kin, the case is referred to the Department of Veteran's Affairs, which investigates the subject's military service. If the decedent is eligible for military burial, DVA makes those arrangements. When a veteran—when veteran eligibility cannot be determined then the remains may be buried on Hart Island, but we also work with other agencies, Department of Homeless Services and various consulates if we suspect that someone is a foreign national, and then beyond that we can also work with NYPD to conduct searches of missing person's databases, maintained by law enforcement agencies and—and Department of Motor Vehicle records and all of that. So, after we exhaust all of that and decide the someone is going to a city burial, our role is to prepare the person for city burial and transport them via one of our Medical Examiner transport trucks to the dock on that that serves the ferry that goes to Hart Island. So, our responsibility is simply that

transport and then handing it off the Department of Corrections.

COUNCIL MEMBER POWERS: Wow, that was an extensive process. I have to—I have to-have to admit that you go--

DR. SAMPSON: [interposing] It's—it's a daunting process.

COUNCIL MEMBER POWERS: Yeah, and—and the—I guess this is the time that you hand it off to the Department of Corrections, but some of the concerns we've heard is also just inaccessibility to people who want to go to Hart's Island. I'm just wondering if you've heard any concerns either about the—the existence of it or—or the operations of it or just the—the—the ability to go there if one desires?

DR. SAMPSON: Nothing more than what I read in the press.

COUNCIL MEMBER POWERS: Got it.

DR. SAMPSON: Yes.

COUNCIL MEMBER POWERS: Okay, thank you.

CHAIRPERSON LEVINE: Thank you, Council Member. Thank you for bring up Hart Island, and for people who don't know the context here, this is a 120 acres. It's in the Long Island Sound. There's two

centuries of history there. It used to be a place for people with substance abuse problems and other or communicable diseases were sent for isolation. There's a Cold War Era missile silos there, but most importantly it's the resting place of one million New Yorkers, and it's currently managed by the Department of Corrections, which is how it's landed on—on Council Member Powers' radar screen, which just makes no sense. It's turned the island into a secure facility. You can't go there without an armed escort. There's essentially no public access except for a very, very narrow window for people who have loved ones buried there, which they have to go accompanied by an armed guard. It's not exactly a way to have an emotional connection to a loved one who might be buried there. This island really should be open to the public because of its historical importance, because of just the beauty and the history of the setting, and—and most importantly so that loved ones can like you would hope in any cemetery connect to deceased family members in the most peaceful, respectful way. So, I have called for transfer of management of the island to the Parks Department, and transfer of the burial function to

the OCME. This has been a longstanding push, which I feel very strongly about and I think that my colleagues do as well. I don't expect you to—to solve this in this hearing, but it's—it's an issue that we plan to continue to push on. Do—do you have any—any statements on the appropriateness of—of such a vision?

DR. SAMPSON: My concern is that the OCME is a science and medical institution. That—that is our area of expertise. We really have no specialized expertise at all in managing the cemetery, interring people. It really is beyond the scope of, you know, anything we've ever thought about doing or our mission as it stands?

CHAIRPERSON LEVINE: I—I understand, but if it's a stretch for you, it's downright ridiculous for the Department of Corrections to have expertise in such matters. So, we'll be continuing to—to push on that front. I do want to ask you about some of the work that you're doing beyond the confines of New York City and you—you mentioned the 100-year history of the office, and I think ate the time that--that we—we formed this office in New York City it, it was way ahead of any other jurisdiction in America, and

that we're still way ahead of any other jurisdiction in America and, therefore, we are doing some work beyond the five boroughs. Could you explain that that is?

DR. SAMPSON: Sure. I think what you're referring to—well, we serve as experts whenever other jurisdictions require expertise in areas that we particularly excel, and unfortunately, one of the areas in which we have really excelled is in the management of mass fatality events. From our response to September 11th, to the Flight 587 that crashed just a couple months later, the Anthrax attack, all occurring within a few months of each other in 2001 we became the unwilling experts nationwide. And I can tell you today that OCME New York City is prepared better than any other city in the United States for a tragic event like for example the school shooting that occurred recently, and again today unfortunately. The—in accordance with Sims OCME is responsible for managing all of this. Any incident that occurs in New York City with fatalities. We have to investigate. We have to recover the decedents from the scene and we need post-mortem examination of every case, and collection

of information from families to facilitate the identification process. So this is a very complex response that we have. We can certainly describe it in great detail, but what I think you are referring to is our UVIS system, which is the Unified Victim Identification System, and that is a system that we developed with Homeland Security money, and it helps the collection of anti-mortem information from families and then matching up that anti-mortem information with post-mortem information that the Medical Examiners and anthropologists are getting after the processing of the remains. This is a system that will greatly facilitate identifications in New Jersey for—and many jurisdictions around the country are using our system including New Jersey, which is an advantage since any attack here would affect the whole Tri-State Area. In particular, most recently UVIS was activated in Las Vegas, the Las Vegas shooting. The—we have had a long and wonderful relationship Clark County and Las Vegas. We have trained with them and, in fact, during the shootings—after the shooting when they set up the Unified Victim Identification System there, three of our experts went out there to-to assist.

CHAIRPERSON LEVINE: Three of them you said?

DR. SAMPSON: But that's-

CHAIRPERSON LEVINE: How many—how many did we send?

DR. SAMPSON: Three.

CHAIRPERSON LEVINE: Three. Alright, well, that's—it's—it's great that we're able to do that.

DR. SAMPSON: Yeah, we always stand ready to assess because these expertise are—are very, very important when they're needed.

CHAIRPERSON LEVINE: So, as I mentioned earlier the Opioid epidemic has unfortunately really expanded the workload of your office. Toxicology testing is very important in such cases, and one reason because it's often Fentanyl—Fentanyl, sorry, that is the cause of death. It's not—it's not explicitly the opioid, but we have a problem with Fentanyl being mixed in, and so last year I believe your office got another million or two to expand your capacity for Fentanyl testing. Could you report on that, and whether you're currently now adequately resourced for those functions?

DR. SAMPSON: Yes. So, as part of the investments made through Healing NYC, the lab introduced a new method of screening for not only Fentanyl, but 30 synthetic opioids. So, these are Fentanyls that have been doctored up to be different kinds of drugs, and if this—and its drug scene is always changing. So, our Toxicology Lab has to stay on top of all of this, and develop new testing as drugs change on the street.

CHAIRPERSON LEVINE: [interposing] And what—what are—what are some examples of—of synthetic opioids? Would we know the name?

DR. SAMPSON: They have complex chemical names. They are--

CHAIRPERSON LEVINE: [interposing] And how prevalent is this?

DR. SAMPSON: It's what you do--

CHAIRPERSON LEVINE: How prevalent is that in the—in the supply of opioids?

DR. SAMPSON: It's becoming more and more prevalent. You know, we seen Fentanyl, but then we also see these other basically analogs of Fentanyl, but have just been chemically modified a little bit.

CHAIRPERSON LEVINE: So, these are not plant based, and they're—they're created in labs?

DR. SAMPSON: And they're created in labs.

CHAIRPERSON LEVINE: Including potentially in the five boroughs. There's illicit workshops that are creating the synthetic opioids?

DR. SAMPSON: This is not my area of expertise, but my belief is that most of these—these drugs are coming from abroad, not from the homeland.

CHAIRPERSON LEVINE: Can you trace the origin based on the chemical markings?

DR. SAMPSON: That's—that's a very interesting question, and we have had several cases now where exactly that has been very important, and we work with the district attorneys or U.S. attorneys who are investigating that to help, you know, draw the line between how these drugs got into New York.

CHAIRPERSON LEVINE: Got it. It's almost like tracing illegal guns. You can determine if they were bought in—from a—a road dealer in Virginia. You can go after the source so maybe it's the same.

DR. SAMPSON: [interposing] That's exactly right, and I just—I have to again

congratulate my Toxicology Lab. They have done outstanding work, and I tell you without doubt that they are performing testing at absolutely on the cutting edge equivalent to and exceeding any lab including private labs in the United States.

CHAIRPERSON LEVINE: So, unfortunately, every single city agency gets some money from the federal government. I say unfortunately because that's vulnerable in the era of a very hostile administration, particularly an administration, which is hostile to public health interests. Does our office receive federal funding?

DR. SAMPSON: Yes we do.

CHAIRPERSON LEVINE: What—what is that? How much is it?

DR. SAMPSON: So, in particular we receive about $3 million in federal grant funding for DNA work, about a million—well, a million from—I'm sorry. The—that pays for criminalists, overtime supplies, education, and also federal research grants that help keep s on the cutting edge as a DNA laboratory developing Next Generation Sequencing, protonix research and those sorts of things, and then in addition to that, we also get grants from NIJ,

National Institute of Justice and the Urban Area Security Initiative in the-to the tune of about a million dollars as well to support ongoing training and staff to support a mass fatality response.

CHAIRPERSON LEVINE: Well, I know the Trump Administration has made the—the—the indefensible threat of cutting health research funding. I'm not sure of the extent to which that has affected you, but you reasonably that any of your federal stream are currently at risk?

DR. SAMPSON: We have no reason to believe that at this time.

CHAIRPERSON LEVINE: Okay, well we will hope that will continue to be the case, and—and we will monitor it closely. I just have one final follow-up question on the capital needs that Council Member Powers raised. So, you mentioned that you're looking for a new site for your building. So, you're not intending to rebuild at the current location, and I'm wondering then are you looking to be nearby? Do you need to be in Manhattan or could this be anywhere?

DR. SAMPSON: Well, we already have a facility in Queens and in Brooklyn. I think it is

important to have a facility in Manhattan because of the high, you know, the chances of something untoward happening in Manhattan having a mortuary ready to roll quickly close by I think would be an advantage. Also, as you know, our DNA building is onto 26th Street, and I think it's to everyone's advantage to be in close proximity to each other to be absolutely and most efficient that we can be sharing information and expertise. So, that would be our preference.

CHAIRPERSON LEVINE: So, is it fair to say you're looking for a site within several blocks of your current location?

DR. SAMPSON: That would be our preference, but we are working closely with EDC to try to establish a facility.

CHAIRPERSON LEVINE: And that—but that is not then established? You don't have a location yet?

DR. SAMPSON: Correct. We're still working on it.

CHAIRPERSON LEVINE: Okay, well, we'll be anxious to hear. It may wind up in your district [laughter] in December depending on what side of the street you're on.

COUNCIL MEMBER POWERS: I may have a location for you now that we've got it-now that you bring it. [laughter]

CHAIRPERSON LEVINE: Okay. Alright, well, thank you Chief for your testimony and for the—the great service of your office.

DR. SAMPSON: Thank you so much.

CHAIRPERSON LEVINE: We appreciate it. We're now going to move to our public session. So, I'm going to call our first panel, which will be Terry Wilder from New York Medical Examiner Action. Do I have that right?

TERRY WILDER: [off mic] Yes.

CHAIRPERSON LEVINE: Okay, we have Stephanie Ruiz from Live On New York; we have Erica Lessem from the Treatment Action Group; and we have Anthony Feliciano from the Commission on the Public Health System. [background comments, pause] So, I'm going to ask the Sergeant to put a two-minute timer on. We unfortunately have—not unfortunate, it's great. We have a lot of people who want to testify in public, and we want to make sure that everyone has the chance to be heard. So, Terry, would you like to kick us off?

TERRY WILDER: Yes. Hi. Hi, I'm Terry Wilder. I'm actually with New York in the Action.

CHAIRPERSON LEVINE: New York---?

TERRY WILDER: New York in the Action.

CHAIRPERSON LEVINE: Which is what?

TERRY WILDER: So, we're a group that was just formed last year to address New Yorkers living with Myalgic Encephalomyelitis which is a mouthful.

CHAIRPERSON LEVINE: I thought it was Medical Examiner.

TERRY WILDER: No.

CHAIRPERSON LEVINE: But you'll—you'll have to explain what you're working on.

TERRY WILDER: Yes. So, ME/CFS is usually what people refer to this as. There's an estimated between 800,000 and 2.5 million living with this disease in the United States, and we estimate between 52,000 and 152,000 in New York State. It's estimated that about 84 to 91% of people have not even been diagnosed with this disease. It affects more women than men. The main areas of impairment are reduction in the ability to carry out normal daily activities, and there were supposed to be other people with me here today, but they could not make it

because they're too sick. I was diagnosed with this disease on March of 2016 after being very, very sick for several years. I'm here today because there is one medical provider in New York City who's an expert on this disease and takes private health insurance. There are zero dollars in the New York City Department of Health and Mental Hygiene budget. This is a problem because medical providers are unaware of this disease. It is often undiagnosed and misdiagnosed. The cause of ME is unknown. There is no cure for it, and the majority of patients never really regain their pre-disease quality of life. It's—in many reports it is said that people's quality of life is worse than most chronic diseases including heart disease and other conditions. At least one-quarter of people with this disease are bed-bound or homebound. I am one of the lucky one. I'm on kind of the healthier spectrum of the disease, which is why I was able to come here today. Three other people were supposed to come today, but they could not make it. I put in a meeting request with your office about a week and a half ago. I'm hoping that we can meet to discuss this public health crisis more. Chairman Corey Johnson met with us right before he

transitioned to his new role. This is a huge public health crisis. There are literally zero dollars being put towards this disease. I'm very concerned about that. I'm also terrified that the one physician who does see people like me [bell] is nearing retirement.

CHAIRPERSON LEVINE: Thank you so much for speaking out, for coming today and calling our attention to this. Did say how many you estimate—how many people in the five boroughs have this condition?

TERRY WILDER: So, we don't have a good estimate for that because nobody is tracking our disease. We estimate that there's between 52,000 and 152,000 people in New York State. One of the packets of material I gave to you we were able to work with New York State Health Commissioner Howard Zucker, who released a letter last May to over 85,000 physicians informing them about this disease. He calls for people to take this disease seriously, and for physicians and other medical providers to put it on their differential diagnosis.

CHAIRPERSON LEVINE: Well, there must then be tens of thousands in the five boroughs if you have such a higher number in the state, and again,

I'm glad you've come today to speak out on this, and I appreciate your bravery and—and your eloquence on the topic, and look forward to meeting with you and your team in the near future.

TERRY WILDER: Great. I'll go up with your office today.

CHAIRPERSON LEVINE: Great. Thank you. Okay, sir.

ANTHONY FELICIANO: Thank you. My name is Anthony Feliciano. I'm the Executive Director of the Commission on the Public's Health System. I'm going to condense my long testimony. Let me just state that one of the things that we work on as the commission is protecting the public hospitals and the two safety net services that they provide, and I think it is paramount to-to make sure that community advocates with the government can change the narrative about New York City's Tale of two healthcare systems, one which the wealthy and those with better insurance coverage receive the IP care and other state obstacles to timely care and less equality services, and so we want to ensure that the city works with us and other advocates with the Mayor to ensure that in taking pools that the public

hospitals and another safety nets are fairly distributed and to push for the enhance safety net legislation that Governor Cuomo keeps vetoing even though both houses the Senate and the Assembly have passed it unanimous together. I wanted to say that also we have to continue ensuring that our public hospitals are—are well resourced. Even though we have to make them accountable for those resources, it's important to do that, and that also that any affected communities, patients and healthcare workers that are affected by any restructuring efforts must have a direct role in formulating and proposing changes in New York City's Health and Hospitals' structure and services. I do want to mention that you mentioned before Council Member Levine about Access Health NYC. That task force, with the Immigrant Healthcare Task Force have recommended direct access programs for the uninsured immigrants, and we think coming out of that program needs to be continued how to build off of that from Action Health NYC through funding or so on. I also think that we have to continue demanding for fair distribution of state dollars to the public hospitals. Also demand that the state in terms of the proceeds that are

coming out of the conversion of assets from Fidelis [bell] that it changes and moves that forward, but I want to say in terms of the last one is Access Health NYC, which not to confuse it with Action Health NYC is important because you mentioned about reaching the uninsured, and one area that even though there are navigators in ACA, they do not have funding to really do the outreach. It's allowing enrollments, and so the community basically are the key. They reach those hard to reach populations, and we could hit numbers even higher if we expanded to $2.5 million given what you had stated before. Thank you.

CHAIRPERSON LEVINE: Thank you Anthony. It's great to see you again. So, just to understand the last point you were making. You said there's a distinction between Action Health NYC and--

ANTHONY FELICIANO: Access Health NYC.

CHAIRPERSON LEVINE: Got it. Of course, which is the City Council initiative--

ANTHONY FELICIANO: Correct.

CHAIRPERSON LEVINE: --which we strongly support, and you're saying it's currently funded at $2.5 million.

ANTHONY FELICIANO: Yes. It's currently funded at $1.7.

CHAIRPERSON LEVINE: So, you and your coalition members have put in a request to take it up to $2.5 million, and one of the benefits of that would be more outreach for healthcare enrollment?

ANTHONY FELICIANO: Including more boroughs being covered in terms of more CBOs, in terms of communities, and that the Community Service Society will be able to have expansion of their—of their hotline, and we're going to basically (sic) in their trainings and—and our other two partners, Coalition and Federation plus the Welfare to do more of that work, including what we work together in terms of guide because it's not just about outreach and access. It's also knowing your rights to those options and coverage.

CHAIRPERSON LEVINE: Well, I'm a strong supported of the Access initiative. This was championed by our then Health Committee Chair and now Speaker Corey Johnson, and I and others will certainly be pushing for it. We're—we're hoping that as the budget negotiations proceed that we'll have

some good news on that front, but thank you for your advocacy. So, please.

STEPHANIE RUIZ: Hi. Hello. My name is Stephanie Reese. I'm a Social Worker Intern in Live On New York. I will be reading a shortened version of the testimony. The completed version is what has been provided. So, first we would like to thank Chairman Levine and the entire committee for the opportunity to testify today. Live On New York also thanks Mayor de Blasio, Speaker Johnson and the entire City Council for their consideration of senior needs as the FY19 Budget process moves forward. Live On New York is a member organization with a base of more than 100 community based organizations serving over 300,000 older New Yorkers annually. Live On New York also administers citywide outreach program that screens older adults for benefits such as SNAP and SCRIE. Finally, Live On New York administers the Senior Medic Patrol Program for the entire state, a program aimed at preventing costly Medicare fraud, which is integral to the success of our healthcare system as it is estimated that fraud and errors make up roughly 10% of Medicare spending. When looking at New York's healthcare system, it is important that

this view takes on the full landscape of health impacting services and providers. For older adults while services funded through the City Department for the Aging such a senior centers, home delivered meals, affordable senior housing with services, are non-medical by definition, their impact has a uniquely positive effect on the overall health of a senior, and reduction in cost that would otherwise be imposed on our healthcare system. The work of community based service providers has significant health impacts from lowering rates of depression to preventing isolation to even reducing hospitalization rates for older adults. For example, given that studies now show that loneliness surpasses obesity as an early predictor of morbidity, the ability for senior centers to provide socialization is key to combatting this risk factor. Another great example of this value can be found in recent study by self-help community services that look at residents and their Independent Senior Affordable Housing with Services Program. The study compared Medicaid data for residents in self-help buildings in two zip codes, and compared it to [bell] other seniors living in the same zip code over two years.

CHAIRPERSON LEVINE: Thank you so much Stephanie. We love Live On. I don't know how you're going to replace Bobbie Sackman, but I'm hoping you—you show those shoes, and your point is so important. Health is intimately tied to diet, and housing, and even the number of factors, and so if you only focus on the doctor's office, and not some of these broader social needs, then you're really only engaging in half the fight. So, I couldn't agree more and—and we thank you and Live On for—for calling our attention to that.

STEPHANIE RUIZ: Thank your.

CHAIRPERSON LEVINE: Alright. Please.

ERICA LESSEM: Thank you to Chairman Levine, Council Member Barron and the excellent City Council's staff for your commitment to making New York a healthier more equitable place, and to your attention to the growing threat of Tuberculosis in New York. My name is Erica Lessem, and I'm from Treatment Action Group. TAG is an independent activist community based HIV research and policy think tank. We at TAG and our partners representing immigrant communities, housing rights and public health expertise share you alarm at TB's recent rise

in New York. TB is airborne and infectious meaning anyone who breaths is at risk, but as you mentioned, Chair, TB disproportionately affects the most vulnerable, those with weakened immune systems, people living in crowded settings, and our immigrant communities. As you heard from Commission Bassett, despite being preventable and curable, TB is on the rise in New York for the first time in over 25 years. Also increasing at a rapid pace are cases of drug resistant TB, which are more difficult and costly to treat. A single average case of drug resistant TB costs almost $300,000 to treat. This resurgence of TB is a direct result of years of under-investment in the public health response to TB in New York City. Thank you for your commitment stated today to push for restored funding at the city and state level. I include some written testimony, a letter from dozens of your constituents and leading organizations in New York asking for a restoration of New York City funding to the Department of Health and Mental Hygiene's Bureau of TB Control on the order of almost $15 million this year, or, sorry, in the coming year. That would be 60 a $6.3 million increase over the current year's funding. We're making similar

requests at the state and federal levels. Investing in the public health response to TB now will save us billions down the road. It would allow for proactive outreach by community organizations to raise awareness about TB and provide preventive services and screening. It could restore clinic facilities that meet patient needs. I enclosed in the testimony a picture of one of the clinics [bell] in Corona, which is disrepair, and it would allow for sufficient staffing to provide coordinated culturally competed care. I just want to remind us that we're in grave danger of repeating history. The outbreaks in the '70s and '80s that were a direct result of decreased funding for TB cost over $1 billion to control So, we thank you for your attention to TB for the commitment stated today, and we look forward to your leadership to make them come true.

CHAIRPERSON LEVINE: Well, thank you to you and—and TAG for raising the alarm on this. After the Commissioner finished testi—testimony, I was passed a note that was saying—it says that we used to fund TB at $33.6 million a year, and it's now fallen to I forget the exact number, but low 20s, and perhaps the blame lies with the state for the funding

cuts, but this is so serious that in the absence of state funding the city is going to have to step up, and as I observed, when the Commissioner was testifying, the city used to put a lot more resources to this, but those cuts happened under the Bloomberg Administration, but I think it falls on this Administration, particularly in the absence of state funding to step up to the plate, and put more money to this. So, you said we spent a billion dollars--

ERICA LESSEM: [interposing] Yes.

CHAIRPERSON LEVINE: --in the '70s outbreak. What was that spent on?

ERICA LESSEM: The outbreak was in the early '90s, but it was a result of funding cuts in the '70s and '80s. So, there were thousands of case mostly among people in homeless communities it started. That was in an era of very crowded shelter housing, and then it spread—this very drug resistant strain spread into New York City hospitals where people were, you know, compromised. The death rates were very high. I think of 80% of people died who had this strain, and because of funding cuts, there wasn't appropriate treatment, but there also wasn't a laboratory structure in place to be able to diagnose

that TB. So, we have a much more committed health respond today, and the Health Department I think is—is paying much more attention than they were in those days, but we're definitely in danger of repeating history because we're seeing the, you know, increase in trends following a history of decimated funding for TB, and it—it does include a reduction of about 50% in city funding since 2007 levels on top of the cuts from the state and the federal government that we're seeing.

CHAIRPERSON LEVINE: Right. So we used to put maybe $20 million and now it's down to $10 million?

ERICA LESSEM: In 2007, City funding was at $16.4 million at TB.

CHAIRPERSON LEVINE: Right.

ERICA LESSEM: Now it's $8.59.

CHAIRPERSON LEVINE: Got it.

ERICA LESSEM: So, half and yes, the—the total amount of funding was $33.6 after adjusting for inflation in 2007, and now we're at $14.89.

CHAIRPERSON LEVINE: Okay. Well, we will be working with you and other advocates on this

intensely no doubt in the future. Sorry I don't have more time, but thank you for speaking today--

ERICA LESSEM: [interposing] Thank for your time.

CHAIRPERSON LEVINE: --this great panel. Alright, we're going to go next to Susan Robinson Davis. [pause] I think it might be Shakti Castro-sorry-from Boom Health. Sorry if I'm mispronouncing the name. We have Isabella Aveeno (sp?) from Northern Manhattan Improvement Corporation. We have Enrique Jerves (sic) from HANAC and Tammy Ewen from the YMCA of Queens. This is a panel focusing on the wonderful initiative of Access Health. Okay, would you like to start us off? Did you press your button?

SHAKTI CASTRO: Okay. Good afternoon. My name is Shakti Castro, and I'm the Community Engagement Coordinator at the Boom Health Harm Reduction Center in the Bronx. We serve the Bronx community with an array of services including preventions to raise access, housing, legal and advocacy and wellness services. I'm here to support the Access Health Initiative by urging the City Council to fund Access at $2.5 million for the upcoming fiscal year. At Boom we work with people

who exist at the intersections of several marginalized identities. Through Access Health NYC we're able to bring our harm reduction approach to health education, meeting people where they are without judgment and connecting to the services, information and coverage they need to lead healthy lives, and make choices that work for them. The educational workshops and groups that we have conducted it helped us empower our community with knowledge and confidence in a judgment free environment helping them to understand their health coverage and advocate for themselves as patients. Many New Yorkers are navigating a changing and confusing healthcare system, and through Access Health we are able to direct outreach in under— uninsured communities including new immigrants, Spanish speakers and the LGBTQ community. Since we started working with the Access Health Initiative in 2015, we have been able to reach 20,000 individuals through community outreach, workshops, groups tabling events and social media. This fiscal year along we've had almost 40 groups of workshops and events that have helped us reach some of the most vulnerable members of our community, and we've been able to

connect them with info related to diabetes, Hepatitis C, HIV, AIDS and substance use disorder as well as connecting to resources for their mental health nutritional needs. These issues affect a disproportionate number of Bronx residents. We have the highest asthma rates in the state at 47.6 per 10,000, and when it comes to Latinas diagnosed with HIV, almost 48% of them reside in the Bronx. Access Health has helped us to address these entrenched health inequalities through education and linkage to treatment services, and I urge the City Council to continue funding this initiative at $2.5 million. [bell]

CHAIRPERSON LEVINE: That was impeccable timing. If you could—if you could tutor some of my colleagues in the City Council I would be very grateful. I'm a huge believer in the harm reduction model, and—and I thank you for the work you're doing in the Bronx and for speaking out today in this important initiative.

SHAKTI CASTRO: Thank you.

CHAIRPERSON LEVINE: Thank you.

LEMUEL BOYD: Good afternoon. My name is Lemuel Boyd and I am the Health Educator on the

Access Health NYC Initiative at the Bedford-Stuyvesant Family Health Center, a federally qualified health center located in Brooklyn. Our center is a safety net facility that serves the neediest within our community. The Access Health Initiative has opened up a whole new world to the center and the community. The center is more involved in the community advocating and extending itself beyond our routine business. We are working with the community to restored renewed hope to people who previously thought that they were just stacked against them. Recently, a young man approached me while I was standing outside of a drug treatment facility. I began my elevator pitch telling him about all the services we could offer on the spot. I indicated to him our Assurance Navigator who could help him and offer our free HIV and HEP C test. At this point he proceeded to tell me that the Department of Health had contracted him about an STD infection, of which he was very troubled and really burdened. He was not sure of the next steps. I was able to counsel him, and he agreed to get treatment. He has started his treatment and is ready to move on with his life. This story and the stories of many

other represents the everyday life experiences of regular New Yorkers are what driver our work. The Access Health Initiative makes a significant difference. It changes the landscape, it provides hope in the midst of fear and anxiety. It is a pathway for everyone who calls New York City home. Your work at the Council is ever so important. Although we know the budget is real tight, we call on you to refund the initiative and refund it at higher financial commitment of $2.5 million. Thank you for this opportunity and your kind attention.

CHAIRPERSON LEVINE: Now, I'm starting to think that you guys rehearsed the timing of your remarks, [laughter] which would be a great precedent, and so you—you are—your are Lemore is that how you say your first name?

LEMUEL BOYD: Lemuel, Lemuel.

CHAIRPERSON LEVINE: Lemuel?

LEMUEL BOYD: Yes.

CHAIRPERSON LEVINE: So, you're—you are a colleague of Suzanne Robinson-Davis. Is that right, who couldn't be here and just speaking on her behalf?

LEMUEL BOYD: Yes, correct.

CHAIRPERSON LEVINE: Okay, Bed-Stuy Family Health Center is one of the coalition members of Access Health--

LEMUEL BOYD: Correct.

CHAIRPERSON LEVINE: Access. Thank you very much for the work you do, and—and for your testimony today.

LEMUEL BOYD: Please.

TAMMY EWEN: [off mic] Good afternoon, Mr. Chairman and Members of the New York City Council--

CHAIRPERSON LEVINE: [interposing] Could—could you check if your mic is on.

MALE SPEAKER: Make sure the light is on.

LEMUEL BOYD: Press the button.

TAMMY EWEN: This is on. Alright. Good afternoon Mr. Chairman and members of the New York City Council Committee. My name is Tammy Ewen, a Healthcare Navigator at the YWCA of Queens. I'm grateful to this opportunity to testify on behalf of the New York City Initiated Budget for a total of $2.5 million for the Fiscal Year 2019. I would like to say thank you to the City Council Speaker Corey Johnson and New York City Council Committee of Health

for three year's support of our continuous Access Health Program. Access Health in New York City has over (sic) funds training our navigators to keep our train—to keep our skills and knowledge up to date. We are dedicated to provide fair health insurance enrollment services for our clients through the New York State, the fair market place. We could operate with the community-based organizations to help children and families and even to be able to obtain low cost healthcare as—as-as well as social services such as SNAP, assist in rent, assist in housing applications, other free services. We have language translation in Korean, Chinese and Spanish for immigrants who are not speaking English. I would like to share an example of my outreach at Flushing Queens Market last November. I handled healthcare prior to the volunteer who was working at the information booth. She said she did not know we can enroll people to government health insurance. She wanted to wait for her parents in our services because her parents can only speak Chinese. Access Health New York City now becomes a community based program. We need the funds to sustain local health programs for education. This April I would like to

expand New York State of health to assist the consumers with the information about the market place at which was YMCA Healthcare state. I will let the parents know that I can enroll the kids (sic) to government health insurers. We want to ensure as many children as parents and parents as possible are enrolled in healthcare, and health insurance. I'm here today to share my [bell] story and urge the Council for its support of $2.5 million for the Access Health New York City program.

CHAIRPERSON LEVINE: Alright. [coughing] Thank you much. Thank you very much, Ms. Ewen for your great work and the work of the Queens YMCA on this important matter, and thank you to this panel. Next up we're going to hear from Sweeney Ferris, Winn Periasamy from Federation of Protestant Welfare Agencies, Max Hadler from the New York Immigration Coalition, Clara Londono from Plaza Del Sol, Clara Londono form Plaza Del Sol. Mahatiae (sp?) from the Arab-American Family Support Center, and Chris Widelo, of course from AARP. [background comments] Actually, Chris, we're going to put you on the panel so you're partnering with some like-minded advocates. Okay. [background comments, pause]

WINN PERIASAMY: So, hi there. Than you so much. You can just call me Winn. [laughs] That's okay.

CHAIRPERSON LEVINE: Okay, I will. Thank you.

WINN PERIASAMY: My name is Winn Periasamy, and I'm with FPWA, and I'm so excited for the opportunity to speak to you all about Access Health NYC Initiative. It's close to all of our hearts, and we thank you so much for the Health Committee's support over the last few years of this initiative. So, this last year has made it increasing clear what a lot of us always knew that health is critical and can be very unappreciated in terms of what it means to our communities when you don't—when communities of color, when LGBTQ communities, low-income other vulnerable and hard to reach populations don't know that their health access is secure. They start deprioritizing their health, and this affects their ability to holistic and full lives and to really contribute to a city like New York in total, and that's where health outreach services becomes so important and critical. This is what Access Health NYC is about—is about providing

culturally appropriate and responsible, responsive linguistically appropriate services to that people feel comfortable actually accessing their health services, and so we just want really want to encourage the Council to enhance from $1 million to $2.5 million this year so that more organizations and more communities can be served in the way that they deserve.

CHAIRPERSON LEVINE: Thank you, and powerfully stated, and I think you were here earlier—I'm not sure—when we spoke to the Commissioner on one of the important parties you have in this project, which is getting people health insurance, and it is important that government employees be prepared to do that work, but that's not always going to be effective, and we do need people who are on the ground in communities speaking the language literally with the cultural confidence and—and the trust who are also doing that work, and the city actually is putting very little resources if you don't count the Action Health Access Health Initiative to that priority. The state does more. So, I'm a strong advocate for expanding the pool of resources for the

work that—that your organization and others are doing on ground. So, thank you.

WINN PERIASAMY: Thank you.

CHAIRPERSON LEVINE: Alright.

MAX HADLER: Good afternoon. My name is Max Hadler. I'm the Senior Health Policy Manager at the New York Immigration Coalition. Thank you very much to Chairman Levine for call this hearing and for the opportunity to testify for the first time in front of the committee in its current composition. We've hear a lot about Access Health NYC so I wont' go over the same details again. Just to say that my organization coordinates the training for all of the other awardees, and we are front row witnesses of all the amazing work that they are doing, and that we're all doing as part of the initiative, and just want to underscore the importance of growing the funding for the initiative as a way of growing the—the initiative geographically across the city. So, we know that there's amazing work being done by the organizations that have testified here today, and in the other of the 13 Council Districts that are currently funded, but the only way to really stretch this worth beyond that current reach is to enhance the funding up to

$2.5 million. So I want to switch gears and talk about a similarly name very different program, the Action Health NYC Pilot that the city undertook in 2016 and '17, which was a really important initiative to address the challenges that uninsured, undocumented New Yorker continue to face in accessing health dare. Action Health NYC tested important innovations and in improving health access and continuity for immigrants excluded from federally funded insurance programs including enrolling individuals in a branded program designed to link them to a primary care provider and linking services at Health and Hospitals with federally qualified health centers and ensuring enhanced care coordination across those different settings. The pilot evaluation showed that enrollees were more likely to receive preventive services to receive a diagnosis of a chronic condition than a comparable control group, and participants reported that the program made it easier to get healthcare when they needed it and in a more friendly, accessible and less chaotic manner. That said, we are extremely disappointed that the Action Health NYC pilot was discontinued without a concrete plan to incorporate

lessons learned and to build out a sustainable and ensured care program in the city. We strongly urge the city to ensure that the lessons of Action Health NYC are incorporated into Health and Hospitals Fee Scale [bell] Options Program or some other comprehensive initiative and we look forward to working with the Council to ensure that this happens. And I am not as good of a time manager as my colleagues, but I also just want to say that the NYC is very strong supporter of the enhanced funding for TB control that Erica and the TAG group mentioned before because this is a disease that disproportionately affects immigrant New Yorkers.

CHAIRPERSON LEVINE: Thank you, and as you may have heard before, I strongly concur with your statement that we need a solution to permitted broad solutions for undocumented New Yorkers so they have access to basic healthcare services in primary care, and we plan on working with your coalition and others to make that a reality. So, thank you.

MAX HADLER: Thank you.

CLARA LONDONO: Good afternoon. My name is Clara Londono. I am part of Urban Health Plan. I am working at Plaza Del Sol Health Center. Thank you

so much for this opportunity. We at Urban Health Plan has historically working with under-served communities and has brought so to create a presence in the poor and under-served neighborhoods. These neighborhoods also tend to have larger concentration of the three largest population—population without insurance, and has high risk individuals. As a lesson (sic) low-wage workers, immigrants and LGBT population. They object is—is to reach out to and for and engage the population in Corona, Queens, Jackson Heights, Elmhurst and East Elmhurst. I will say to—like to condense everything that we are telling you is that we have a network, a network organization. That's why we need the $2.5 million because we are working with the city. We are working with an organization that the population believe on and we are helping this organization to reach the people that believe in us, and to give the best help, and access to resources that we have here. Without this organization I really think that the city is not providing what you need to provide to the community. Thank you so much.

CHAIRPERSON LEVINE: [Speaking Spanish]

CLARA LONDONO: Corona, Queens, Corona, Queens. Uh-hm.

CHAIRPERSON LEVINE: Okay, just—just clarifying for the record that Plaza Del Sol is in Corona, Queens, and we are very glad that you're part of the coalition, and thank you for speaking out today.

CLARA LONDONO: Thank you.

CHAIRPERSON LEVINE: Muchas gracias. [Speaking Spanish] Donna Tilghman who is a representative of Local 372 as well as Mr. Kevin Allen also from 372, and we are now going to call the great Chris Widelo from AARP, who has a fan club with him today, and every day, and as well as Kimberly McKenzie from the Sylvia Rivera Law Project, and Anna Bower from Transgender and Gender Non-Conforming Solutions Coalition. So, we have a great panel with some diverse perspective, and would—would Donna or Kevin from 372--are they still here? Looks like we missed them. Well, we have to catch them on another round. Okay, Chris, would you like to kick us off? [background comments]

CHRIS WIDELO: Good afternoon, Chairman Levine and members of the Health Committee. My name

is Chris Widelo. I'm the Associate State Director of ARRP here in New York, and on behalf of our 800,000 members age 50 and older in New York City. I just want to say thank you for the opportunity to testify today, and thank you for the numerous volunteers that came out today to be here to support me. So, no surprise. New York City's population is aging and nearly one-third of residents in the five boroughs are over the age of 50, and that group is expected to grow by nearly 20% by the year 2040. The growth for the age 65 plus group is projected to be even more dramatic, a whopping 40% increase, and our city is not just aging, we are becoming more diverse. African-Americans, Blacks, Hispanics, Latinos, African-American and Pacific Islanders account for 62% of New York City residents age 50 and older, and half of all those 65 and older living here were born in a foreign country. We know from our recent report disrupting racial and ethnic disparities solutions for New Yorkers age 50 and older developed in partnership with the New York Urban Leagues, then NAACP, Hispanic Federation and Asian-American Federation that people of color over the age of 50 experience stark disparities in areas of health,

economic security and the ability to live and remain in their communities. All of this means that we must take meeting the needs of older New Yorkers making— all this means that meeting the needs of older New Yorkers needs to become a bigger priority. We are grateful to the increased and baselined funding increases that have been made in the DFTA Budget last year, but aging is not just a Department for the Aging issue. That is why we are here today along with some of our New York City members, and that is why we plan to attend many budget hearings with different agencies. It is time for the needs of aging New Yorkers to be addressed across city government. After all, meeting the needs of aging residents and helping them stay in their neighborhoods is critical to retaining their tremendous economic, social, cultural and family contributions, and it's also the right thing to do. One of the keys to helping our older neighbors to continue [bell] to live in the neighborhoods they call home is ensuring they remain healthy. This is a big undertaking in a city like New York, and there are a number of priorities that have been laid out by the New York City Age-Friendly--New York City Age-

Friendly Initiative, and the age Age-Friendly New York City new commitments for a city for all ages. The report addresses several health disparities particularly as they related to increasing utilization of services among older people including—including those who are homebound. For example, the city's efforts to train health and social—social service workers who with homebound older adults on specific risk factors for injury and illness and best practices for prevention. This is one of the recommendations that has been made, and we're curious as to where the Health Department is with this program, how successful has it been, and how many seniors need better trained providers. Beyond that, the city is looking across networks to improve health outcomes. For example, the effort to forge connections between healthcare provider networks and aging provider network including marketing Falls Prevention Programming—including marketing Falls Prevention Programming to healthcare providers. How successful has that program been? I provided you all with copies of the testimony so I won't take any more of your time, but the bottom line that we hope that all discussions that will happen here today, and in

the future and all budget hearings will consider the needs of aging New Yorkers. Let's disrupt aging together and help ensure that New Yorkers can age safely and happily in the city they love.

CHAIRPERSON LEVINE: Thank you. Thank you, Chris for the incredible partnership that AARP has given to—to the City Council and myself personally, and thank you for coming not just to the Committee on Aging, but to the Committee on Health.

CHRIS WIDELO: Yes.

CHAIRPERSON LEVINE: And as your signs effectively sum—sum up, aging is a health issue and health is an aging issue. It's obvious, and we do need to do more to make sure that we consider the senior's angle to every issue we're considering in this committee, and I very much look forward to partnering with you as—as we formulate policy that is responsive to the needs of older New Yorkers.

CHRIS WIDELO: Thank you. Looking forward to it.

CHAIRPERSON LEVINE: Likewise. Alright, please. [pause]

ANNA BOWEN: Good afternoon Chair Levine and Council staff. My name is Anna Bowen, and

Kimberly and I are a part of something we call the Transgender and Gender Non-Conforming Solutions Coalition, which is a coalition of separate organizations including Sylvia Rivera Law Project, an anti-violence project, the LGBT center, Make the Road New York, Opioid Project. It goes on and on. In 2015, the LGBT Caucus of City Council worked with the organizations to start a series of community forums to hear what the transgender and gender non-conforming community or TGNC community needed from City Council. Last fall after having gone through five borough forums, we put together a policy brief called Solutions out of Struggle and Survival, and we have boiled that down to six budget asks. We are making these asks of the Mayor, and in the event that the asks are ended (sic) to the Executive Budget we'd like Council's support in making this happen. The specific reason that we're here today is we've made a pitch to DOHMH and HMH for a TGNC healthcare liaisons program. One of the things that has come out of conversations with community member, and Kimberly can talk about this a little bit more, is people need connections to care. The TGNC community just started speaking broadly and faces health outcomes that are

I'd say more dire than non-TGNC people. TGNCLGB people in a 2015 Health and Human Services Survey, 15.8% of TGNC respondents are reported in fair or poor health compared with 9.6% of cisgender LGBT respondents. There are many similar statistics like that, and so one of the things that came out of these borough wide sessions was the need for healthcare liaisons, people who can connect people—connect people to doctors, connect the doctors to health insurance, connect patients to after care [bell] and overall make sure that patients get the best experience possible, and this would cost $820,000. That's the most of the money for staffing with a little left over to advertise the services, and I'll turn it over to Kimberly.

CHAIRPERSON LEVINE: Thank you Anna. Okay, Kimberly.

KIMBERLY MCKENZIE: Hello, and good afternoon. My name is Kimberly McKenzie, Director of Outreach and Community Engagement at the Sylvia Rivera Law Project. I would first like to give so much thanks to Chair Mike—Mark Levine of the committee and also all of the Council members here in attendance. At the Sylvia Rivera Law Project we work

go guarantee that all people are free to self-determine their gender identity and expression regardless or income or race and without facing harassment, discrimination or violence. The Sylvia Rivera Law Project is a collective organization founded on the understanding that gender identity is— that gender self-determination is an inextricably intertwined with racial, social and economic justice. Therefore, we seek to increase the political voice and visibility of low-income people and people of color who are transgender, intersex or gender non-conforming. The Sylvia Rivera Law Project works to improve access to respectful and affirming social, health and legal services for our communities. We believe that in order to create meaningful political participation and leadership we must have access to the basic needs of survival and safety from violence. As part of the Transform Coalition in which several community organizations serving transgender, gender non-conforming or intersex people, health reforms in all five boroughs to understand the needs of our community. We have taken an active role in addressing the needs of our TGNC communities. Through our TGNC community recommendations we have

collaboratively formed a policy brief called Solutions Out of Struggle and Survival, available at AVP.org/solutions to expand policy and budget solutions with specific proposals to funding initiatives that support TGNC lives and economic sustainability. I am here to testify on behalf of supporting our proposed TGNC Healthcare Liaison Program, [bell] which we have proposed to DOHMH and the Health and Hospitals Corporation, and would cost $820--$820,000. As part of our coalitional efforts, we recommend that DOHMH and the Health and Hospitals Corporation provide supportive services that include hiring a culturally—a culturally competent TGNC liaison at city hospitals who understand and respect TGNC identities and their healthcare needs. Too many time our communities have witnessed incompetent services at hospitals that don’t address them with incorrect pronouns, and have witnessed further, more experiences of discrimination, which contribute to the risk of negative healthcare outcomes and violence against our communities with little to no access to affirming healthcare services. It is vitally important that TGNC communities feel affirmed, and visible in these public health settings while taking

the next steps to ensure supportive affirming healthcare of our TGNC communities and overall visibility of TGNC communities' lives. This is why we need DOHMH [bell] and H&H to fund the TGNC Healthcare Liaison Program, and if they do not, we seek Council support in funding this new program. Thank you, and you may contact me at kimberley@SROP.org.

CHAIRPERSON LEVINE: Thank you Kimberly and Anna. I—I want to read this report that you've produced. Maybe you can send it to my office.

KIMBERLY MCKENZIE: Absolutely. We'll be happy to.

CHAIRPERSON LEVINE: And I appreciate you bringing this up. Are there any private hospitals, which have such positions? Is this a case where the public sector is behind the private sector?

KIMBERLY MCKENZIE: I'd say that--

ANNA BOWEN: [off mic] Sorry. Don't mind me. It's all in the program. (sic)

KIMBERLY MCKENZIE: I'd say that Mount Sinai is sort of recognized as one of the leaders in doing this. I mean--

CHAIRPERSON LEVINE: They have a dedicated surgical unit now--

KIMBERLY MCKENZIE: [interposing] Yeah, the Surgical Unit. They have a lot of staff covering this, and I'd say that H&H actually also has like a TGNC liaison, and they do have healthcare navigators in the system. But what we're—we're looking for is given what, you know, Kimberly has heard through organizing work, you know, people are lacking connections to after care. Doctor's aren't really making the connections with insurance that they need, and so having dedicated TGNC like navigators or as we're calling them liaisons is something that's not within the H&H system that would really—and that we'd also like to see applied across the entire, you know, public and private systems. That would be really, really helpful.

CHAIRPERSON LEVINE: I'm sorry that we don't have more time to go into this now, but I truly thank you for bringing it up, and would love to work with your team on this issue.

ANNA BOWEN: And we have a longer list of all of our other proposals attached to my testimony.

CHAIRPERSON LEVINE: I look forward to hearing more about that. Thank you so much to both of you. We've been joined by Donna Tilghman from 372, please. Just press the button.

DONNA TILGHMAN: Hi, good afternoon, Health Care Committee Chair Levine, and distinguished members of the committee. It is the honor or Local 372, New York City Board of Education Employees, District Council 37 AFSCME to present testimony on behalf of the 279 substance abuse prevention and intervention specialists otherwise know as SAPIS. We represent under the leadership of President D. Francois, I. I'm also joined here by my partner, my coach--

CHAIRPERSON LEVINE: [interposing] Yes, I—I understand she's now here. She can come up. Is it Ms. Sobero?

DONNA TILGHMAN: No, Kevin Allen.

CHAIRPERSON LEVINE: Oh, sorry.

DONNA TILGHMAN: He's here and Executive Vice President on this BID of Local 72, Executive Treasure David Key (sp?).

CHAIRPERSON LEVINE: Alright.

DONNA TILGHMAN: So, what I would like you to know that SAPIS provide an essential prevention and intervention services for the 1.2 million public school students in New York City. Today's youth are more vulnerable than ever before due to the growing drug abuse epidemic. Our message is a simple one: The more support and resources we can offer to our at-risk youth, the more productive they will be in the future. So, we're coming before you today to ask you for your continued commitment to our students by providing a total of $4 million in next year's budget for SAPIS, a renewal at the $2 million and to—and to add and to maintain the current staffing levels and to add additional increase of another $2 million to hire and additional 25 counselors to reach thousand or more children, and Mr. Allen and our Local would like for you to know that we love our children and we love our work. Not only do we counsel children, we also provide—we have a—we have a curriculum whereas we teach children social skills [bell]. It's three minutes? We teach children social skills, leadership, decision making, and we also teach our kids how to be assertive, how

to give into peer pressure and things of that nature. So, we don't only do drug prevention.

CHAIRPERSON LEVINE: And are you yourself, Ms. Tillman a SAPIS Counselor?

DONNA TILGHMAN: Yes, I'm a SAPIS counselor and so is Mr. Allen.

CHAIRPERSON LEVINE: [interposing] And what—what--?

DONNA TILGHMAN: I work in an elementary school and Mr. Allen works in the middle school.

CHAIRPERSON LEVINE: Which—which school are you at? Are you in 101?

DONNA TILGHMAN: I am in PS 189 in the Bronx in District 11.

CHAIRPERSON LEVINE: And how long have you been a Counselor?

DONNA TILGHMAN: I started in December of 2001.

CHAIRPERSON LEVINE: Thank you so much for dedicating your life to this career. It's very impactful, and more needed now than ever I'm afraid.

DONNA TILGHMAN: Thank you.

CHAIRPERSON LEVINE: And thank you for testifying. Mr. Allen.

MR. ALLEN: We just wanted to add that we find ourselves very unique because we cover students from A to Z and from kindergarten to the 12th grade, and we noticed that being 12-month employees, we are very rare. Most guidance counselors are social workers. Usually you have defined niche that they use and also with us being able to use evidence based curriculum that addresses the needs. When we look Life Skills, Too Good for Drugs and Second Step, and Guiding Good Choices and tending to be a summer evidence based curriculum, we find that we're able to impact, but what we're more excited about is our impact in schools that sometimes is quantitative and sometimes is qualitative. You can see the results automatically and some cases over a period of time we see the results and we're excited about that, and the ability to create what we call positive alternatives. We have several counselors with various skillsets whether it's in the arts, whether it's music, rather it's drama, whether it's creativity, playwriting or film making. The school that I'm in which is also the same building as Ms. Tilghman, is in the process of building a recording studio, and a dance studio because we know the positive alternative is to the

solution, and if I tell you what to do, it will urge you and make you more proactive about what not to do. So, we have a compassion. We have a heart for this work, and we believe that the best is yet to come in New York City.

CHAIRPERSON LEVINE: Well, thank—thank you, Mr. Allen, and very eloquently stated. With the unfortunate rise of the opioid crisis, we need you and your colleagues on the front lines, and if I'm not mistaken the ranks of SAPIS counselors have dropped over the yes.

DONNA TILGHMAN: Yes.

MR. ALLEN: Yes.

CHAIRPERSON LEVINE: I believe there was 500 at a peak, and then it's now down to 300. Do I have that right?

DONNA TILGHMAN: Yes.

MR. ALLEN: At one point—at one point less than a decade ago there was 1,200.

CHAIRPERSON LEVINE: So—so we had—in 1,200 and--

MR. ALLEN: [interposing] 1,200 to less than 200.

CHAIRPERSON LEVINE: --in the early 2000s, and how it's down to how much?

MR. ALLEN: 271 to 275.

CHAIRPERSON LEVINE: So, that's—we're moving in exactly the wrong direction considering the crisis we're confronting, and I will certainly be working to push for more funding to expand the ranks of SAPIS Councils in this Budget. Thank you for speaking out today, and for sharing your stories.

DONNA TILGHMAN: Thank you so much. Thank you.

MR. ALLEN: Thank you.

CHAIRPERSON LEVINE: Okay. Alright, so our next panel we're going to get Mahati (sp?) Isabel Avejo (sp?) Elaine Budrick Hunter, Alicia Vassens. Sorry if I'm mispronouncing that, and Robin Vitale. We only have four chairs, so I'll as the fifth of you if you're here just to wait a moment and then we'll rotate out when one of you finishes speaking. We have a lot folks who want to testify. It's a good problem to have. Would you like to kick us off?

MAHATI: [background comments] My name is Mahati. I'm Health Program Manager and New York City Health Navigator at the American Family Support

Center. I'm not going to read from here because again I have it. I'll make it short and sweet. I'm here for—to advocate the budget for Access Healthcare, and the budget is $2.5 million because we deal with immigrant population. We need the money to reach out to our immigrant population, our—who doesn't speak English so we could advertise in their native language, and we do lots of outreach in the Arabic language for our community, and we serve our American South Asian. So, we have staff who speak all these languages. If you include us in the budget, if you add more community based organizations we'll reach out to more immigrant population in the city. Thank you.

CHAIRPERSON LEVINE: Thank you very much for testifying for—for—for working on this important issue. We really appreciate it.

MAHATI: Thank you.

CHAIRPERSON LEVINE: Yes.

ISABELLA AVEENO: Hi, good afternoon, everybody. My name is Iabella Aveeno and I'm always in your neighborhood Councilman Levine doing access to healthcare work, doing outreach. So, and I—I wrote it, so I don't want to leave anything important

out. So, I work for Northern Manhattan Blue Corporation, and I'm their Outreach Coordinator for Access to Healthcare, and as you all know, we all know many New Yorkers have no access to healthcare and other essential services that affect the quality of their lives, and for diverse reasons, many people are not aware that they qualify for health insurance, and sadly many other people even though they're aware, they're so afraid to come out and ask for the services that they are entitled to, and that impact the quality of their lives, and also their ability— ability to provide for their families. And I have been doing something different, but this morning, I received two phone calls that I had to take care of, and one is a 69-year-old immigrant, undocumented battling pancreatic cancer, and they have been denied medical care, and I—I had to fight, we have to fight as an organization to secure that he could have access to emergency healthcare but also through this site and thanks to the guidance of the NYIC and Anthony Feliciano's amazing trainings that they provide for our organizations, I was able to find a way to secure that he is receiving treatment at one of our public hospitals. Then I—I—right before

jumping on the train, I get another phone call from a desperate family. Their 22-year-old college student has been diagnosed with Hodgkin Lymphoma, and they need help securing health insurance, and securing that he is going to get treatment, and so that's the reason I was late. Now, I have an excuse, but these funds are needed. I joined NMIC last year [bell] to do access to healthcare, and one of the projects that I was able to do is hike the high as a way to bring more than 1,000 community members to one of our public parks and have different vendors and health navigators provide information about health insurance. Human right, access to healthcare is human right, and we need to continue taking pride in being a progressive society necessarily that embraces diversity, and that we recognize the humanity in all those regardless of their--

CHAIRPERSON LEVINE: [interposing] Thank you.

ISABELLA AVEENO: --immigration status. Thank you.

CHAIRPERSON LEVINE: Thank you, Isabella. NMIC is very near and dear to my heart, and the—the anecdotes you've shared about real life stories of

impact really were great to hear and it proves how important the program is. Thank you very much.

Good afternoon. My name is Elaine Hunter and I want to thank Chairman Levine and all the members of New York City Council's Committee on Health for the opportunity to present testimony on behalf of Samaritan Suicide Prevention Center. I'm honored to speak to you and share my perspective as someone who has a Ph.D. in Neuroscience from Columbia, but is also a volunteer with experience working on the Samaritan Suicide Prevention Hotline. As you know, suicide, the tragic and ultimate symbol of untreated mental health has increased in the city the last three years causing almost as many fatalities as homicide and auto accidents combined. As you're probably aware, each year 1 in 5 New Yorkers experiences a mental disorder, and that 60% of them will never receive care, destroying lives and families and costing New York $1.8 billion for suicide alone. But suicide and suicide prevention should not just be confined to the mental health sector for every health problem, but from Alzheimer's Diabetes and AIDS Deziga has potential that can lead to depression and self-destructive behavior.

Samaritans experienced answering over 1.3 million calls from New Yorkers in distress tells us that every illness no matter its severity, often leads people to feel overwhelmed and insecure, hopeless and helpless, powerless to overcome their situation creating a potentially serious problem. In fact, research tells us that the majority of the general practitioners fail to perform even basic depression screenings on their patients during exams possibly missing the golden opportunity to identify psychological and behavioral problems, and even more important to be in a position to address it. This is why Samaritans encourages you to advocate for enhanced suicide prevention training, not just for the school system, but for every city contracted health agency and department and emphasize the need for them to utilize at least some basic depressing screening tool and suicide risk assessment model. Samaritans has a proposal before the Council Speaker for Fiscal Year 2019 to address this need that we hope you will consider supporting. Our caring community Suicide Prevention Education Project will advance integration of suicide prevention education and procedural planning for government, non-profit,

academic [bell] and community organizations that serve New York City's culturally diverse at-risk populations. I thank the Committee for its time and appreciate your attention to the physical and emotional wellbeing of all New Yorkers.

CHAIRPERSON LEVINE: Thank you so much. It's—it's a difficult topic and one that people shy away from addressing unfortunately, and it needs to be brought to the light of day, and so we—we appreciate you being here and speaking out. I look forward to working with you. I am needed for a vote across the street in the Education Committee. So, you're going to be in the hands of our capable colleagues and Health Committee member Council Member Keith Powers. So, I'm sadly going to miss Robin's testimony, but I know that AHA is doing amazing work and that you have a very holistic view of health policy that goes way beyond directly heart related matters to really a concern for the broader health of New Yorkers, and I thank you for that, and I will be back in a few minutes. So, pick it up. [background comments]

COUNCIL MEMBER POWERS: I'm the less attractive Chair, but nevertheless, please continue.

ROBIN VITALE: Thank you Council Member. As mentioned, my name is Robin Vitale. I serve as the Vice President of Health Strategies for the American Heart Association here in New York City, and we are thrilled to be here to present kind of the top notes of our budget priorities that we're recommending for the city to invest in for FY19. Specifically, we're looking for the city to dedicate dollars to support the mission of the American Heart Association by helping to promote access to healthy foods for New Yorkers preventing tobacco addiction as well as improving management of high blood pressure. Under that headline of improving access to healthy foods, we actually have three proposals. We would recommend that the city invest and additional $15 million into helping to expand SNAP by the Health Bucks Initiative. As you're like aware, 1 in 5 New Yorkers receives SNAP, and we really do believe that both the economic potential as well as the health benefits is deserving of these additional dollars. The second proposal under the Healthy Food Access has to do with creating a city specific healthy food financing initiative. This is something that was done at the state level several years ago then

unfortunately now is no longer no longer being funded, but it had tremendous impact not only in bringing fruits and vegetables into underserved neighborhoods, but also to again spur the economy. Ultimately a $10 million investment by the city we anticipate would have significant impact building new food markets in neighborhoods that desperately need that retail space, and lastly under Healthy Food Access we're recommending a $3 million investment to help really bolster the work being done in our smaller retail stores. These corner stores or bodegas are often the lifeline for food access to many of our New Yorkers, and we believe that a $3 million investment will help to expand the already good work that's going on in the city through the Shop Healthy Program, and really being more comprehensive in its approach working with other community based organizations to expand the reach into that—those much needed neighborhoods. Focusing in on tobacco control, as you might be aware, a HUD rule is about ready to be implemented. [bell] and we know that many New Yorkers in public housing unfortunately have higher rates of tobacco addition. So, we're recommending a $2 million investment to

help support that community specifically with our station efforts, and lastly on hypertension. We know the city is doing some significant in this space. We'd recommend a $1 million investment to make that work sustainable, and impactful for the long term.

COUNCIL MEMBER POWERS: Thank you and just a follow-up question. I apologize for missing the other testimonies. I've—I presume we have paper copies. So, I'll be able to catch up. On the—on the retail access to food, small retailers, I assume, presume there is large retailers, too, that could be part of that, and I know some large retails have taken steps in the last few years to try to spend some of that, you know, some options whether it's fruits and vegetables or otherwise. Can you tell me more about that program funds and—and—and you're asking I think for $3 million. I think it was $3 million for that program, but what—where would that money go to, and what is actually—what are the options that are—that are—well, what's the success rate I guess as well ensuring that the food actually goes into the corner store, and then comes out of the corner store and home with somebody?

ROBIN VITALE: Yeah, I appreciate that the opportunity to expand because I was trying very hardtop hit that two-minute mark and it's a challenge to get all of the detail in with the timeline.

COUNCIL MEMBER POWERS: [interposing] It's challenging, we know.

ROBIN VITALE: So, the $3 million investment we're recommending would be specifically focused through the City Health Department to establish or really expand an existing program and really enhance it. The city's Shop Healthy Initiative works with current business owners to really promote the sale of fruits and vegetables through those markets. So working with the bodega owner whether it's providing some business expertise, bringing things in like refrigeration, making it more manageable for these businesses to sell perishable items like fruits and vegetables. You also mentioned the larger store market, which I think is another key aspect because we know many small markets have shut down in neighborhoods that are obviously quite challenged in the space of healthy food retail, and that's where the second proposal would really be most impactful. The $10 million request that we're making

there would establish a city specific healthy food financing initiative. This is the program that was established at the state and usually about six or seven years ago under the line: Healthy Food Healthy Communities Fund. The Healthy Food Healthy Communities Fund with a $10 million investment from the state was—worked with the Empire State Development Corporation and through that mechanism developed a public/private partnership, and they ultimately had a private company provide a Tier 1 match for that initial public investment. It will bring a $30 million nest egg. It was then targeted into under-served neighborhoods across the state of New York. Ultimately, it resulted in about 25 new food markets built in neighborhoods that met very specific criteria regarding what that under-served population means and it also resulted in almost 2,500 jobs. So, it really is a fantastic mechanism for both heathy food as well as healthy economy. We'll gladly send more information to you Council Member with more information detailing those proposals, but we think all three will are an answer to what the city might be looking for because it not only helps to create that environment to provide fruits and

vegetables in the neighborhoods that need it most, but in looking at the SNAP expansion with Health Bucks, we're really thinking about incentivizing New Yorkers to purchase these fruits and—fruits and vegetables. So, it's kind of a—a nice comprehensive approach to consider for the—the city to invest in.

COUNCIL MEMBER POWERS: Great. Thank you. I know that the Char—I'm filling in but I know that he recently—and all—all the members of the committee appreciate all four of you being here, and providing testimony. Sometimes these are some of the most important parts of the—the hearings when we get to hear directly from the public about priorities that could go into—directly into our communities and our neighborhoods, and so I—I found when I was Chairing the Criminal Justice Committee that some new ideas about ways that small investments could be often very large gains, came out of the public testimony. So, I appreciate everybody being here, and providing that testimony. I look forward to reviewing it with the Chair and the staff as well to see how the Health Committee can, you know, advocate for investment or what. I think they'll have a

tremendous gain. So, thank you for all—for all of you being here.

ROBIN VITALE: Thank you for your time.

COUNCIL MEMBER POWERS: Thank you.

ROBIN VITALE: Thank you.

COUNCIL MEMBER POWERS: Oh, I think we have—I think we have one more. [pause] Thank you. We're going to hear now from our next panel. We have a few names on here. I think we have five names, but only four seats. This is the world we now live in but we—we'll ask with the first person has finished testimony if they don't mind to just get up and get—give their seat over. So, we're going to call Paulette Spencer from the Bronx Community Health Network; Enriquo—Enrique Jerves from Access Health NYC, HANAC; Micah Bookman from Promise Academy; Michael Rogers from New York Road Runners; and Felicia Cannon, student with the New York Road Runners. Thank you. [background comments, pause] I think the fifth one is with Road Runners, right? It's a student here? Thank you for being here. So, we'll—we'll get started. Road Runners, if you want to start.

MICHAEL ROGERS: Thank you Council Member. Good afternoon. My name is Michael Rogers and I serve as Vice President for Youth and Community Runner and Daytime New York Runners. Thank for this opportunity to testify. Our mission at New York Road Runners is to help and inspire people through running. I'm here today to talk about physical education in New York City schools, which as you is falling short of serving children and meeting New York City's, New York State standards particularly those in low-income communities and have—and leaving students in danger of become abused and remaining habitually inactive throughout their lives. While New York Road Runners is best known for producing the TCS New York City Marathon, the organization is also the largest non-profit provider of free fitness programs in the city. NYRR has been providing free physical education and fitness programs for our city's youth since 1999 and in 2016-17 school year, our school based free programs fitness events and resources touch 115,000 New York City students at over 800 schools. Although this city has made significant progress in recent years, there's still a long road to make quality physical education and

fitness accessible to all children. New York Road Runners is devoted to making that happen. Our free programs are dedicated—are designed to help all kids Pre-K through Grade 12 build their confidence, motivation and desire to be physically active for life. Hence, the term physical litter—physically literate. We're in the midst of a health and obesity crisis in New York City especially for children. Physical activity in schools lays that—lays the groundwork for a healthy life. It is not an extra. It is a crucial service. Last year, the city responded to this crisis by announcing a universal PE initiative that promises a designated physical education space in all New York City schools by 2021. This—this initiative acknowledges that vital role physical activity has on a child's education [bell] and the city has—excuse me New York Road Runners is here to help provide free programming. We have a request for $500,000 in initiative funding to support our Signature program, Rising New York Road Runners and we have a student here to share a little bit about her experience.

COUNCIL MEMBER POWERS: Got you. I will note that you were—you didn't beat the clock despite

being with Roadrunners, but I will—do you want to have--

MICHAEL ROGERS: Yep, that's it.

COUNCIL MEMBER POWERS: Thank you for being here. Next for the testimony.

FELICIA: Good afternoon. My name is Felicia, and I'm a Rising New York Road Runners' Youth Ambassador. My love for running started back in 2016. I was a sixth grader in MS 577 in Williamsburg, Brooklyn. I joined the NYRR Youth Running program in my school. I was very shy. So, I figured running would help keep me active, something I enjoyed. I liked having the support of my team mates with the pressure you get from participating in team sports. This program teaches the fundamentals of running. It doesn't matter if you are the fasted or slowest, each child is accepted into the program and everyone is treated equal. The program is based on growing a child's ability to stay healthy through running by teaching exercises, drills and proper nutrition. I had no idea then where this would take me and how I'd fall in love with the whole organization. My mother is disabled and cannot take me running on days when our programs do not have

practice. So, when looking on their website she realized the have an open run program which is held in 13 parks throughout the five boroughs. We attended an open run in Brooklyn Bridge Park. I sat on a bench nervous to join in. Everyone knew everyone and was having so much fun. Then one director approached me and asked me if I would like to join in on the run. That day changed my life. I was among teachers, doctors, lawyers, engineers, all people that make a community together running as a family, everyone supporting, teaching and guiding one another. This was great. Not only did I have a safe running environment with people guiding and helping me, but they taught me how to believe in myself, be confident and help—help me be the leader I am becoming. I now attend three open runs in different regularly. Last summer, I was chosen as one of the NYRR running—Rising New York Road Runners Ambassadors. In this program the boys and girls that are chosen, attended a writing and media class held over the summer. Although my favorite part of this program was the multiple public speaking courses we were given. They are continuously helping me throughout my life—my life whether athletically,

academically, emotionally or socially. As an Ambassador, we are trusted with the responsibility of not only representing the Road Runners organization, but we are also becoming young leaders in the running community [bell]. We are the future of not only—not only as athletes but as part of our community, and the best part is this program is completely free. I'm not captain of my school tract team. I volunteer at a youth running program teaching younger children about running. I am now running on a competitive level with the hopes of making the Junior Olympics one day, and I—and I have received an academic scholarship to Monsignor McClancy High School. I can't wait for my 14th Birthday when I can officially become a volunteer for youth events for Road Runners and begin to impact the lives of younger runners as my life was impacted. Thank you.

COUNCIL MEMBER POWERS: Thank you. That's wonderful and your public speaking skills are—are on display. You did a great job, and although I will note that I'm partial to Saint Francis Prep Track Program where I ran in High School, but glad to hear—and congratulations in the scholarship and I'm

welcoming the Chair back also. We'll switch—we'll switch our chairs then. [pause]

CHAIRPERSON LEVINE: It seems like a missed a good one. [laughter] I can't wait to read your testimony. Thank you for being here, Felicia. Sorry, who—are you? [background comments] Please. [pause] [background comments]

ENRIQUE JERVES: No, you—okay. So, I can continue. You can hear me better now. So, I am here to request $2.5 million in the 2018-2019 Fiscal Year Budget. The Heal Access Program has been an opportunity for HANAC to educate and spread that information in the—among the community who are the greatly affected by the appropriate distribution of resources, and I would like to say that because, you know, that health is a human right for immigrants and also Latin-American citizens in the United States. But the system is very complicated even for—for all locals even worse for—for immigrants. So, pretty much with the existing budget we were able to provide more than 60 literacy workshops in the year, which is two days outreach in which in each state we were able to outreach 50 people in each activity, and also we were able to provide different workshops in which we

explain about affordable care chance and immigrant care rights, instructions on complementing emergency Medicaid Application, local social services exists to permitting in a specialty care Medicare held care up on how immigrants can get access to different kinds of services. By providing an extra funding or increasing the funding, we were able to meet different amounts from the community received in the Queens. Unfortunately, as you know, immigrant services are often underserving immigrants. Communities do not have access to [bell] free medical facilities to obtain healthcare services. On my testimony, I brought you a brochure with so many of the campaigns how we were able to use the funding of how we are helping our community. Thank you for your time. I don't know if you have any questions.

CHAIRPERSON LEVINE: [Speaking Spanish]

ENRIQUE JERVES: Yeah, I understand. Yeah. No, that's fine, yeah.

CHAIRPERSON LEVINE: Thank you so much for your testimony.

ENRIQUE JERVES: Alright, thank you.

CHAIRPERSON LEVINE: Good afternoon. My name is Micah Bookman. I'm the Health Educator at

Harlem Children's Zone, Promise Academy One. Thank you for the opportunity to be here as a representative of my community to ask for better access to healthy foods in our community. So, in my work as a health educator, I've spoken with hundreds of students and parents all with the same issue that they want to east healthier, they want to live healthier lives, but they don't have access to the resources they need to make this a reality. The desire exists, and we're calling on you, the City Council to help meet that demand. As part of the solution to the diet and heath issues that we spoke about earlier, we support funding programs that expand access to healthy food especially SNAP and Health Bucks. These programs have a tangible real positive impact on our community. You heard the testimony on the broad and complex issues surrounding food access, but I would like to zoom in a little bit for you. In my community wellness groups, mothers tell of having to travel and extra 30 minutes out of their way to find a grocery stores with sugar free snacks. Lack of access results in parents who find farmer's markets overflowing with fresh vegetables near their work by Union Square, but not by their

homes in Central Harlem. They can forget about finding the minimally processed non-GMO and organic items we know that will improve their diet. When my high school students go to buy snacks at the corner store after school, they can get 42 grams of processed sugar for $2.00 but a smoothie with fresh fruit cots $6. My first grade students are so inundated with unhealthy options they can instantly recognize French fries and a hamburger, but can't recognize zucchini and Brussel sprouts. In these people in my community there's a hunger for fresh and nutritious options. There's a hunger for a healthy future without the pains of obesity, Diabetes and heart disease. [bell] There's a hunger for quality produce, for meat that is organically raised free of hormones and snacks that are not processed. By funding Health Bucks and SNAP as well as the other issues that Ravi mentioned, we'll be able to bring those healthy options to our community. Thank you.

CHAIRPERSON LEVINE: Thank you, Micah, and I couldn't agree more about the importance of this challenge, and we simply have profoundly unequal distribution of healthy food options especially affordable healthy food options and that problem is

arguably getting worse as supermarkets close all over the city, but particularly that is stating in low-income areas where there weren't supermarkets, certainly not enough healthy supermarkets to begin with. So, thank you for bringing this to our attention.

PAULETTE SPENCER: Hello. My name is Paulette Spencer and thank you very much for holding this session today. I am the Community Engagement and Policy Analyst for the Bronx Community Health Network, which is a federally funded health center, a non-profit community based organization that assures access to quality affordable primary preventive Medicare—medical care and support for social services to residents regardless of their ability to pay or immigration status. My work focuses on BCH and CDC funded Bronx Racial and Ethnic approaches to Community Health Champs Program, which goal is to reduce obesity in communities like the Northeast Bronx where obesity rates are disproportionately high through initiatives supporting healthy nutrition and increased physical activity. Over the past three years our Bronx Reach Champs' 34-member coalition of individuals, local community and Parks Friends

Organizations, and agencies including the New York City Parks Department and Policymakers all committed to making our parks safe, welcoming and accessible for community use through walking, running and other fitness activities in seven central and northeast Bronx parks. To date, our Reach Champs Coalition's community led parks based activities have become available to more than 300,000 community residents in the neighborhood surrounding our parks. Our coalition partner, New Yorkers for Parks created a set of seven visitor park guides in English and Spanish that have been widely distributed to community residents and received high praise from the CDC. In addition to the parks guides, through our coalition' park based activities, we have increased community demand for park based programs and services, and with our local community volunteers we have created [bell] a tool measure parks usage. With an enhanced park programming and increased access to parks, our coalition can eventually measure the long-term change in the health statistics in the surrounding communities, examine the extent to which park usage and improved access to parks are related to improving a community's health. Thank you.

CHAIRPERSON LEVINE: Thank you and, you know, as the form Parks Chair, I—I couldn't agree more, and we appreciate you bringing up that important connection.

PAULETTE SPENCER: Thank you.

CHAIRPERSON LEVINE: Alright, thank you panel. We're going to move onto the next group, which is Anna Krill from Sharing and Caring; Laura Redman from New York Lawyers for the Public Interest; Bianca Martachek from ME Action; ME, which I now know does not stand for medical examiner; a Melissa Tarks from Self—also a patient activist with I believe the ME Coalition, and Joel Ernst [pause] and we are one chair short. So, we'll just ask you to swap out as people finish speaking, and would you like to start us off?

ANNA KRILL: Good afternoon. My name is Anna Krill. I am Founder and President of Astoria, Queens Sharing and Caring. On behalf of the Board, the staff, and the individuals we help annually I would like to thank the Council for its past support of Sharing and Caring. This year we're seeking $250,000 in Council funding, an increase of $100,000 from our FY18 award under the Cancer Services

Initiative. This funding will allow us to expand our Be a Friend to Your Mother high school outreach program, and our partnership with the Queens Public Library. Under our High School Outreach Program, we educate our young men and women about becoming more proactive in their wellbeing and healthcare and about also the risks that could be minimized of getting breast, testicular or other cancers. We ask them also to bring this message home to their parents and to encourage their parents to go for screening where it is appropriate. Under our initiative, we have reached this past year, about 2,000 young men and women and indirectly have affected 4,000 lives through this initiative. Our partnership with the Queens Public Library has enabled us to provide health, mental health and Cancer information to adults in an environment that is a part of the library's ESOL Community Health Programs. Since July 17, we have served over 250 adults through 13 programs at six libraries throughout Queens. Council funding has allowed Sharing and Caring to assist those coping with cancer with an emphasis on the medically underserved, uninsured linguistically isolated populations throughout [bell] Queens County.

As a 25-year breast cancer survivor myself, I want to thank you very, very much for all your support in the past, and urge you to please fund us again this year, and to help us expand our life saving programs.

CHAIRPERSON LEVINE: Well, thank you Anna for that great statement, and for all the work that Sharing and Caring is doing, and appreciate you being here. Thank you.

YONKA MARTICHEK: I am so pleased to meet all of you. My name Yonka Martichek, and I would like to—I came here to raise awareness for illness of ME/CFS. It's Myalgic Encephalomyelitis/Chronic Fatigue Syndrome. I want to talk about it because I have ME, and it took four years for me to get diagnosed. I was bedridden for four years and now I just wanted to come and show you that I had to go to so many doctors and I have all these, you know, it's not bills. I have insurance, but I do—I don't think I had to go through all this to get diagnosed, but I would really want to see funding for research about this illness. All the doctors I had to see was—they couldn't diagnose me until in November 2017 I finally got diagnosed after private doctor a lot did blood work on me that cost $10,000 and it's just so much

money, and a lot of people need help, and I'm—I'm here because I—I want people to know that people go through—this is real illness. Like this is not something that it's made up, you know. It's all—it's—I'm sorry to talk ME. It's very touching to me because it's me. You know, I—I couldn't walk and have started to learn again. I couldn't speak. It's like a debilitating illness, and it—it—it should get funding, you know. Thank you.

CHAIRPERSON LEVINE: Thank you, Yonka for—for your bravery in battling this condition, and—and coming and speaking out today so powerfully. I know that one of—one of the frustrating aspects of the condition is that it's hard to get diagnosed, and perhaps hard to be taken seriously because there's no outward signs of—of illness at first, but we're glad that—that you have preserved, and that you appear to be doing better, and I look forward to meeting with the group soon, and hopefully you can be part of that, and—and we can work together to get more attention and resources.

YONKA MARTICHEK: Thank you.

CHAIRPERSON LEVINE: You got it.

YONKA MARTICHEK: I appreciate it.

CHAIRPERSON LEVINE: Alright.

LAURA REDMAN: Hello. Good afternoon. My name is Laura Redman and I'm the Director of the Health Justice Program at the New York Lawyers for the Public Interest. Thank you Chairperson Levine for having us here today. The Health Justice Program, you know, the pair rides a kind of racial justice and immigrant focus to healthcare advocacy in New York City and New York State, and I'm here mostly today to talk about the City Council's Immigrant Health Initiative. We are very honored and thank you that NYLPI and our community health center partners received $500,000 in funding through the initiative last year. This support has allowed us to expand our work educating immigrant New Yorkers with serious health conditions, their healthcare providers, legal services providers about healthcare access and connecting individuals to state funded Medicaid. Through this funding we've been able to train and give informational presentations on immigrant access to healthcare to hundreds of community based organizations, healthcare providers and legal services providers. We also provide comprehensive screenings and legal representation to individuals

particularly those in health emergencies and including holistic support for their intersecting needs. In light of the newly understood risks and our focus on health emergencies, our individual cases have become more complex. We've developed a nuanced practice and we take the cases that no one can. I'd like to tell you a few stories. For example, our clients Ms. O, a Bahrain National and Bronx residents within end stage renal disease had received treatment from Broadway dialysis in Elmhurst for many years. She had no hope for any additional care until she met NYLPI through here doctors. We filed her first immigration application two years ago, enrolled her Medicaid and got her on the transplant list. After many here-goes (sic) and more legal advocacy from NYLPI she now has a new kidney and a life changing outlook. Another client Ms. T is an undocumented mother of two in Elmhurst who has ALS, and had lost most of her ability to speak. We gathered a multi-disciplinary team at NYLPI and completed a comprehensive immigration, health and services evaluation. We filed a Humanitarian Deferred Action Immigration Application on behalf of Ms. T [bell] which was nearly eight inches thick. We worked with

a social worker and eventually connected her to full comprehensive State Medicaid. I'll be very quick. I also want to talk to you about the other half of the work that we Immigrant Health Initiative, which is about seeking to improve access to healthcare in immigration detention facilities. For New Yorkers, city residents held in detention, NYLPI provides individual and systemic advocacy to improve healthcare. We do outreach across the city with medical providers, legal services providers and community based organizations and we have built a volunteer network of medical professionals to perform evaluations. We also provide support to the City Council funded New York Immigrant Family United Project attorneys. One more example. After nearly 18 months in immigration detention, our client Mr. S's body was racked in pain, covered in sores and acutely vulnerable to infection. His health had deteriorated drastically in detention due to poor care. He had lost over 60 pounds. He couldn't leave his bed and move his fingers. He faced the immediate risk of permanent joint disintegration. Immigration attorneys reached to us in crisis, and our team worked through the weekend to activate our Volunteer

Medical Network, assess the dangers of his declining health, and made a case for humanitarian release to the Department of Justice. Four days later, he walked out of Immigration Detention.

CHAIRPERSON LEVINE: Laura, I'm sorry, if you can just summarize because we have another hearing that needs to start in this room--

LAURA REDMAN: Okay.

CHAIRPERSON LEVINE: --in two minutes.

LAURA REDMAN: Okay, so I'll just say that we ask for the funding to continue for Fiscal Year 2019 with an enhancement of $100,000 to keep the network. Thank you.

CHAIRPERSON LEVINE: Thank you, Laura. Thank you to NYLPI. You do work—incredible work in so many arenas, healthcare being one of them, and—and we will certainly be fighting to renew and expand that initiative.

LAURA REDMAN: Thank you.

CHAIRPERSON LEVINE: Sorry. We're short on time. We have another hearing momentarily in the room. Please.

MELISSA TARKS: Hi, my name is Melissa Tarks. I'm also an activist with ME Action, and have

ME/CFS. Youi heard from a friend of my earlier, Terry Wilder who spoke about--

CHAIRPERSON LEVINE: [interposing] Sorry, Melissa. Just one moment. I want to just ask if Alyssa Vassen is still here. She could approach. We understand she was going to testify earlier. Sorry. Well, you—you can continue.

MELISSA TARKS: So, in my mid 30s I would have never imagined that I'd be over—almost five years into living with a disabling illness that science was yet to understand. I has largely been unstudied by the medical community. It's a disease that strikes the young and healthy leaving them disabled. An estimated 75% of patients are unable to work and many are homebound, and bedridden, and I myself have been mostly homebound for the past five years of having this illness. This is probably the most prevalent devastating disease that you and unfortunately your doctor has never heard of, It's called Myalgic Encephalomyelitis, more commonly referred to as Chronic Fatigue Syndrome. It's a very unfortunate term for the illness because it does not remotely being to capture how severely disabling this illness is, and ECFS affects up to 2.5 million in the

U.S. Over 75% of them women. It affects more people than MS and HIV-AIDS. It profound neurological immune—immunological and metabolic dysfunction resulting in a level of functional impairment that's worse than major medical conditions like congestive hear failure, Type 2 Diabetes and Multiple –Multiple Sclerosis, and yet federal funding falls far shot of the funding for diseases with similar disease burden and prevalence. Unfortunately, the extended absence of research funding since the CDC first investigated this illness in the 1980s has resulted in widespread stigmatization and misinformation regarding ME/CFS resulting in most people with ME/CFS not even having access to a doctor with basic knowledge of this illness. [bell] I myself was lucky in that it only took me a year and a half to get ill—to get diagnosed, and I actually do have excellent insurance, and have managed to continue working throughout these past through years from home, but most people are not fortunate. The CDC awarded three—awarded funding for three Centers of Excellence in the U.S. to focus on this disease, two of which are located in New York State at Columbia and Cornell, and yet if you go to Columbia and Cornell,

if you go to for example the Neurology Department, you will be hard pressed to find any clinician who knows anything about treating this illness, and most likely if they have heard of it, will suggest treatments that result in direct harm to patients. So, we really encourage the committee to help us educate medical professionals from clinic—clinical perspective because it is so desperately needed. In a city where there are actually a few specialists here, and centers like Columbia, Cornell and Sloan-Kettering, who are doing research on this, and yet you can't find a clinician at those centers who can treat you.

CHAIRPERSON LEVINE: Thank you so much, Melissa for your bravery as well in speaking out, and we wish you much success in battling this disease, and I look forward to working with you and ME Coalition on this issue. Thank you so much for speaking out today.

MELISSA TARKS: Thank you.

CHAIRPERSON LEVINE: Joel.

JOEL ERNST: Thank you, Chairman Levine and members of the Committee on Health for hearing my testimony today. My name is Joel Ernst, and I'm here

representing a community of scientists that are working to eliminate Tuberculosis. I'm a professor at the NYU School of Medicine and I've spent the last 25 years working to inform developmental TB vaccines. With funding support from the National Institutes of Health and the Bill and Melinda Gates Foundation, we've made dramatic progress, but we do not yet have a vaccine that we know works well enough to eliminate TB. I'm here to appeal for your support of increased resources to combat the growing public health threat of Tuberculosis as we scientists work to develop vaccines and other improved measures to improve, to eliminate TB worldwide. The World Health Organization coined the phrase TB anywhere is TB Everywhere because it is easily spread through the air. TB is on the rise again in New York City as its multi-drug resistant Tuberculosis, which is even costlier and more difficult to treat. If we don't prevent and treat TB properly, it will continue to spread taking many more lives, and costing much more to control. New York City provides its best—its own best lesson for the importance of adequate funding for TB control. The TB control budget was reduced in the 1970s, and by the 1980s, a combination of factors

resulted in near tripling of TB cases in New York City for 1984 to 1992. Rebuilding the TB Control Program in New York City came at a cost of over a billion dollars. However, funding has now been reduced again, and New York City has now seen a 10% increase in the number TB cases. Are we seeing the repeat of what happened between 1984 and 1985 or will we have the resources to prevent an increase in TB cases this year, the next year and the next year after that? In addition to my work as a TB researcher, I'm a clinician who has witnessed the devastation TB can cause. I've had TB patient die on a street corner of pulmonary hemorrhage. I've had several patient paralyzed by spinal involvement by TB, and I've had multiple patients [bell] whose brain involvement with TB was irreversible despite our best treatments. Despite my optimism that we will develop TB vaccines, we're not there yet. Now, is the time to invest more in the tools we already have for TB control to save orders of magnitude more work and resources that avoid further suffering from TB. Thank you.

CHAIRPERSON LEVINE: Thank you, Joel, for speaking out. It would be a tragedy if we repeated

the mistake of the 1970s. We need to act assertively now to head this off, and we're definitely going to be fighting for more money in the—in the city budget and for restoration of cuts at the state level as well. So, thank you for speaking out about this. Please.

DANIELLE CHRISTIANSON: Hi. My name is Danielle Christianson, and I'm here on behalf of God's Love We Deliver. God's Love we Deliver is New York City's leading not-for-profit provider of medically tailored home delivered meals and nutrition counseling for people living with life threatening illnesses. God's Love provides services to the most underserved and isolated populations in our city, those who are sick and unable to shop or cook for themselves. We look—we believe that being sick and hungry is a crisis that demands an urgent response, and for New Yorkers living with complex illnesses, God's Love is the only service that stands between them and hunger. Each year, God's Love continues to grow to meet the demand. Last year alone we delivered over 1.7 million meals to 7,000 men, women and children living with severe illnesses throughout the New York City Metropolitan Area. God's Love is

unique do to our focus on nutrition. We have seven registered Dietician Nutritionists on staff who tailor each meal to meet a client's specific medical needs. Our services ensure that those living with life altering illnesses have access to food while also improving health outcomes and reducing healthcare costs. Research shows medically tailored meals are low cost high impact health intervention. A recent pilot study showed a 28% drop in average monthly healthcare costs for patients battling life threatening illness who receive medically tailored meals. Also a 15%--50% fewer hospital admissions and 20—and those who receive medically tailored meals had a 23% more likely to be discharged to their homes rather than another facility. God's Love is an integral part of the city's safety net that provides unique service not currently offered by other providers. God's Love serves people of all ages. For example, if you're under the age of 65 living with cancer, and are unable to shop or cook for themselves—for yourself, you only option in New York City is God's Love We Deliver. God's Love is also a vital safety net for seniors. Seniors living with serious illnesses that require very specific diets

are unable to be served by home delivered meal providers currently contracted by DFTA. As a result, these clients are regularly referred to God's Love from DFTA contracted meal providers. Despite this fact, we have no contractual [bell] relationship with DFTA. To ensure we can continue to provide—to provide services, which improve the health outcomes of the increasing number of New Yorkers in need of our services, we ask the Council to join us in calling on the Administration to include funding for medically tailored home delivered meals in the FY19 Budget. Thank you.

CHAIRPERSON LEVINE: Thank you. So, how much funding are we currently allocating to that? You say you're asking for an increase.

DANIELLE CHRISTIANSON: So, currently it's a—we're at $90,000 for the Speaker request and we have no contractual relationships. So, this is all discretionary funding, and I believe last year was about $188,000 out of our $17 million budget.

CHAIRPERSON LEVINE: Well, I know that you do incredibly important work, and—and—and certainly you need more resources for that, and we

will support you in that effort. Thank you very much.

DANIELLE CHRISTIANSON: Thank you.

CHAIRPERSON LEVINE: Okay, this concludes our very, very productive hearing. [gavel] Thank you all so much.

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 21, 2018